

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EDITH		First	Middle	Last	2a. DATE OF DEATH Month Day Year JANUARY 15, 1969		2b. HOUR 11:00		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 18, 1900		6. AGE (In years last birthday) 68		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MAGNOLIA, W.VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 75 EAST MAIN STREET		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 75 E. MAIN STREET	
14. FATHER'S NAME First Middle Last HENRY KASECAMP		15. MOTHER'S MAIDEN NAME First Middle Last RUTH TWIGG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) N.A.		16b. SOCIAL SECURITY NO. 218-07-9613D		17. INFORMANT MRS. ARTHUR FEMI MORANTOWN, R.F.D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week - years -									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec , 19 68 , to Jan 15 , 19 69 , that (I) (we) last saw the deceased alive on 1/15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John B. Davis				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/17/69	
22d. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.				22e. ADDRESS 2 BROADWAY, FROSTBURG, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1/18/69		23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART ALLEGANY, MD.			
24. FUNERAL DIRECTOR MARILYN M. SOWERS				ADDRESS HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR DATE 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH at 11:50 PM		
Estella							Balsley		January 12, 1969 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Female		White		6/29/1871			97 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Virginia		U. S. A.					Allegany County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Allegany County Infirmary			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Allegany		Cumberland		YES		129 Mary Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Richard			Balsley		Charity			Diddle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
No			218-12-3228		P.O. Box 599, Allegany County Infirmary records			Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute renal insufficiency</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Chronic ASH with hypertension</u>										Many years	
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Chronic glomerulonephritis</u>										Many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1967, to Jan. 12, 1969, that (I) (we) last saw the deceased alive on Jan. 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
John R. Lippert MD									1-13-69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
John R. Lippert MD			Memorial Hospital, Cumberland, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		Jan. 15, 1969		Rose Hill Cemetery			Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.								JAN 16 1969		Allan S. Judge	

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00003				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00003											
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR					
Jessie				June		Barkman		January 24, 1969				5.10 P.							
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
Female		White		June 12, 1890				78 YRS.											
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH													
Maryland		U.S.A.				Allegheny, Cumberland, Md.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		413 Pulaski Street				Housekeeper -At Home													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER											
Maryland		Allegheny		Cumberland				413 Pulaski St.											
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last	
James				Oliver		Hinkle		Susan				Virginia		Willison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				Address									
No				217-18-4534		Mrs. Ruth Browning				413 Pulaski St Cumberland, Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>												7 days							
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
(b) <u>Hypertensive cardiovascular disease</u>												20 yrs.							
DUE TO, OR AS A CONSEQUENCE OF																			
(c) <u>Diabetes mellitus</u>												20 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
<u>Generalized arteriosclerosis</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
none				none				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
				HOUR A.M. Month Day Year P.M. 19				None											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
				None															
22a. I certify that (I) (this hospital) attended the deceased from Jan. 19, 1968, to Jan. 24, 1969, that (I) (we) last saw the deceased alive on Jan. 24, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. 5.10 P.M.																			
22b. SIGNATURE				DEGREE				ATTENDING PHYS.				MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
James P. Hallinan M.D.																Jan. 25, 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS															
James P. Hallinan M. D.				140 Bedford St., Cumberland, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				1/27/69				Rose Hill Cemetery				Cumberland Allegheny Maryland							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Silcox-Merritt Funeral Service				Cumberland, Md.				JAN 27 1969				[Signature]							

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
EVA			M.		BEEMAN	1/29/1969			8:48 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
Female		White		3/1/1903			65 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MD.		USA.					Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Frostburg			Miners Hospital			House wife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			Allegany		Midland			None	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
George			H.		Stevenson	Sarah			E. Winters
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			NONE		Clinton Beeman (Husband)		Midland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>HEVD C Cerebral accident</u>								2 weeks	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>repeated cerebral accidents years</u>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> , to <u>Jan 29 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 29 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>John B. Davis</u>			1/30/69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
John B. Davis			Frostburg, Md. 21532						
23a. BURIAL, CREMATION, or other disposition (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2/1/1969		Memorial Park		Frostburg, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn			Lonaconing, Md.			FEB 3 1969			

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1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day YRS.		2b. HOUR
DEANA		W.		BITTINGER	1 10 69		2:30P
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
FEMALE	WHITE		5-30-68		—		YRS. 7
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				ALLEGANY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PENNA.				MEYERSDALE		RT. 4	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
HERMAN		BITTINGER		CATHERINE		BEEMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				MEMORIAL HOSPITAL		CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Pneumonia, fulminating</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
<u>Downs Syndrome - Cong Heart Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> , 19 <u>69</u> , to <u>1/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
<u>Robert J. Dawson</u>		<u>1/13/69</u>		DR. ROBERT J. DAWSON			
				22e. ADDRESS			
				CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		1/13/1969		St. John's Cemetery		Meyersdale Som. Pennsylvania	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William C. Price Fun. Home, Meyersdale, Penna.				DATE JAN 22 1969		<u>Charles Judge</u>	

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DEANA W. BITTINGER 1 10 69 2:30P

FEMALE WHITE

2-30-68

PENNSYLVANIA U.S.A.

ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL

HEMMA

MEYERSDALE

X RI. A

HEMMA

BITTINGER

CATHERINE

DEEMAN

MEMORIAL HOSPITAL

CUMBERLAND, MD.

DR. ROBERT J. DAVISON

CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00006		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00006	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
HARRY		C.		BROOKS	JANUARY Month Day 1 Year 69		4:38 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		WHITE Colored		5/7/98		70 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
W. VA.		USA				ALLEGANY	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD.		ALLEGANY		CUMBERLAND		13e. STREET AND NUMBER	
						104 MECHANIC ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
JOSEPH				BROOKS	BELL		BRADY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		214-05-5271		MEMORIAL HOSPITAL		CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Gunshot wound to the chest</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart failure</i>							
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>after 11:00</i> , 19 <i>69</i> , to <i>Jan 1</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 1</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Blane M. Schindler</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>1/4/69</i>	
22d. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		12/4/69		Romney		Romney Hampshire W. Va.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SHAFFER FUNERAL HOME		ROMNEY, W. VA.		JAN 8 1969		<i>Charles J. J...</i>	

SHAFER FUNERAL HOME ROANOK, VA.

BLAKE M. SCHINDLER, D.D. 43 GREENE ST., CUMBERLAND, MD.

JOSEPH

BROOKS

BELL

BRADY

NO.

ALLEGANY CUMBERLAND X

100 MECHANIC ST.

CUMBERLAND

MEMORIAL HOSPITAL

W. VA.

USA

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MALE

WHITE SKIN

SLY/30

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HARRY

C.

BROOKS

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1. DECEASED NAME (Type or print) Mattie		First Mattie		Middle Campbell		Last Campbell		2a. DATE OF DEATH Month January Day 15 Year 1969		2b. HOUR 240P	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 7-15-82		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS 86 DAYS 86		IF UNDER 24 HRS. HOURS 86 MIN. 86	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? Allegany, USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hotel Hammersmith		12b. KIND OF BUSINESS OR INDUSTRY Hotel					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Kennedy Homes Apt. 305			
14. FATHER'S NAME First Edward Middle Williams Last Williams		15. MOTHER'S MAIDEN NAME First Creasy Middle Williams Last ADAMS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 206-03-5444		17. INFORMANT Address Mrs. George Ashby 320 Central Ave. Cumberland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) spontaneous stroke DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis, diabetes										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-2-1969 , to 1-15-1969 , that (I) (we) last saw the deceased alive on 1-14-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Krings		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-15-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/18/1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md					
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS 230 Baltimore Ave.		25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item#23aFilm#G408 1/22/69 vmp CERTIFICATE OF DEATH										
00008										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Edwin			Howard Capler			1 Month 14 Day 69 Year		6:35 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
m		W		2/28/1890		78 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
48		U.S.A.				Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Hearing Home, Cumberland Convalescent and			Retired		none		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		LaVale Cumberland				319 Algonquin Hotel Baltimore Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John A. Capler			Bessie Meldrum							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no			217-07-6120		Violet F. Goff		Sech. LaVale, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>403X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic contracted Kidneys</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>								2 weeks 12 days 2 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1-1962</u> , to <u>1-14-1969</u> , that (I) (we) last saw the deceased alive on <u>1-14-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>H. Kings</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-15-69</u>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
burial		1-18-69		Oak Hill Cemetery		Bradford, Pa. McKean Pa.				
24. FUNERAL DIRECTOR <u>John J. Hafe, Jr.</u>					ADDRESS Md. 230 Balto Ave. Cumberland		25a. REC'D BY REGISTRAR JAN 17 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the non-payers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00009												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00009																																			
1. DECEASED-NAME (Type or print) CORDELLA												First E. Middle CARDER Last												2a. DATE OF DEATH JANUARY Month 30 Year 1969												2b. HOUR 4:20A																							
3. SEX FEMALE												4. RACE WHITE												5. DATE OF BIRTH 7/24/93												6. AGE (In years birthday) 75 YRS.												IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.											
7a. BIRTHPLACE (State or foreign country) MARYLAND												7b. CITIZEN OF WHAT COUNTRY? USA												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												9. COUNTY OF DEATH ALLEGANY												Md											
10. CITY OR TOWN OF DEATH CUMBERLAND												11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL												12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)												12b. KIND OF BUSINESS OR INDUSTRY																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND COUNTY ALLEGANY												13c. CITY OR TOWN CUMBERLAND												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>												13e. STREET AND NUMBER RT. 3, BEDFORD RD.																							
14. FATHER'S NAME GEORGE												First LONG Middle HAYES Last												15. MOTHER'S MAIDEN NAME MARY												First HAYES Middle HAYES Last																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)												16b. SOCIAL SECURITY NO.												17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.												Address																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac failure																																																											
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												21f. LOCATION Street or R.F.D. No. City or Town County State Guyh Ripley Md																																			
22a. I certify that (I) (this hospital) attended the deceased from 1/17/69 , 19__, to 1/30/69 , 19__, that (I) (we) last saw the deceased alive on 1/30/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE William J. Williams												22c. DATE SIGNED 1/31/69												22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS												22e. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												23b. DATE Feb. 1, 1969												23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cath Cem.												23d. LOCATION (City or Town) (County) (State) Frostburg, Alleg Md																							
24. FUNERAL DIRECTOR John J. Hafer, Jr.												ADDRESS 230 Balto Ave. Cumberland												25a. REC'D BY REGISTRAR FEB 3 1969												25b. REGISTRAR'S SIGNATURE James																							

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CERTIFICATE OF DEATH

1	CORDELLA	E.	CARRER	JANUARY 30 1989	11:30A
2	FEMALE	WHITE	12/2/1923	15	
3	MARYLAND	USA	X	ALLEGANY	
4	CUMBERLAND	MEMORIAL HOSPITAL			
5	MARYLAND	ALLEGANY CUMBERLAND	X	RT. 2, BEORD RD.	
6	GEORGE	LONG	HARRY	HAYES	
7				MEMORIAL HOSPITAL CUMBERLAND, MD.	

DR. R. J. WILLIAMS
 122 S. CENTRE ST. CUMBERLAND, MD.
 1989

CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
GRACE		E.		CASSEN	JANUARY 9, 1969		6:05PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
FEMALE	WHITE		6-18-94		74 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U. S. A.				ALLEGANY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		NONE		NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		ALLEGANY		CUMBERLAND				SYLVAN RETREAT
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
UNKNOWN		CASSEN		EMMA HILLEARY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO		219 54 2096		MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>14 days</u> <u>year</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/5</u> , 19 <u>69</u> , to <u>11/9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11/9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>George M. Simons</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>11/9/69</u>		
22d. PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS				22e. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		JAN. 12, 1969		ROSE HILL CEMETERY		CUMBERLAND, MD.		
24. FUNERAL DIRECTOR BIRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JAN 16 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0010

0010

GRACE	E.	CASSEN	JANUARY 2, 1983
FEMALE	WHITE	6-18-94	VA
MARYLAND	U. S. A.	X	ALLIANCE
CUMBERLAND	MEMORIAL HOSPITAL	LONG	HEALTH
MARYLAND	ALLIANCE CUMBERLAND	X	SYLVAN RETREAT
UNKNOWN	CASSEN	ELMA	MILITARY
219 24 2096-MEMORIAL HOSPITAL, CUMBERLAND, MD.	21		

DR. GEORGE H. SIMONS

CUMBERLAND, MD.

JAN. 12, 1983 ROSS HILL CHURCH

CUMBERLAND, MD.

JAN. 10 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last MARY VERONICA TK CHANEY			2a. DATE OF DEATH Month Day Year JANUARY 10, 1969		2b. HOUR PM 9:05		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-6-1899		6. AGE (In years lost day) YRS. 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.			13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1 BOX 352 A	
14. FATHER'S NAME First Middle Last WILLIAM FLETCHER HARVEY			15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE ELLEN MURRAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMB. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>8 days</u> <u>yes</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> , 19 <u>69</u> , to <u>1/10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. P. James</u> MD.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>1/11/69</u>			
22d. PHYSICIAN'S NAME (Type) DR. W. P. JAMES					22e. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE Jan. 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		23d. LOCATION (City or Town) (County) (State) Terra Alta W (County) (State)		23e. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		
25a. READ BY REGISTRAR JAN 15 1969					25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>					

00011
 JANUARY 10, 1969 9:02
 CHANEY
 MARY ANN

11-5-1898
 WHITE
 FEMALE
 U. S. A.
 X
 ALLEGANY

CUMBERLAND
 MEMORIAL HOSPITAL
 HOUSEWIFE
 W. VA.
 MINERAL RIDGELEY
 X
 RT. 1 BOX 352 A

HARVEY
 MEMORIAL HOSPITAL, CUMB. MD.

DR. W. P. JAMES
 CUMBERLAND, MD.

JAN. 15, 1969
 JAN. 15, 1969

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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00012

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00012

1. DECEASED-NAME (Type or Print)			First Middle Last Thomas Aloysuis Collins			2a. DATE KNOWN OF DEATH Month Day Year 1-20-69			2b. HOUR 19 12:20p M			
3. SEX Male	4. RACE White	5. DATE OF BIRTH Mar. 11, 1916	6. AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year January 20, 1969			2d. HOUR 12:20p M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany			Md.			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dox Sacred Heart Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist helper			12b. KIND OF BUSINESS OR INDUSTRY Textile			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 249 Main			
14. FATHER'S NAME First Middle Last Thomas F Collins			15. MOTHER'S MAIDEN NAME First Middle Last Playgie Morgon									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. (If no give war dates of service) W.W. 11 217-10-7245		17. INFORMANT Aleda Collins			ADDRESS Westernport, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
										"		

19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED January 20, 1969 ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/23/69		23c. NAME OF CEMETERY OR CREMATORY St. Peters			23d. LOCATION (City or Town) (County) (State) Westernport, Md.					
24. FUNERAL DIRECTOR <i>L. Boal</i> ADDRESS Westernport, Md.						25a. REC'D BY REGISTRAR DATE JAN 24 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>				

CURRENT TRENDS

CORONA VY SOLEROS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00013 CERTIFICATE OF DEATH 00013										
1. DECEASED-NAME (Type or print) EDWARD			First Middle Last Joseph CONWAY			2a. DATE OF DEATH Month 01 Day 20 Year 69		2b. HOUR 3:45 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 06-19-06		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. REPAIRABLES OR INDUSTRY LIQUORS, INC.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER BOX 451, MT. SAVAGE, MD.	
14. FATHER'S NAME First Middle Last JOSEPH CONWAY			15. MOTHER'S MAIDEN NAME First Middle Last (MC KENZIE) FLORENCE CONWAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-05-5809		17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL-900 SETON DR., CUMB.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNK		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 1-19-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>L. Michael Glick</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-20-69				
22d. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK				22e. ADDRESS 126 N. SMALLWOOD ST CUMBERLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/23/69		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Allegany, Cumberland, Md.				
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS MD. 21502		25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
GEORGE FUNERAL HOME, 202 GREENE ST., CUMB.,										

GRACE

ALLIANCE COUNTY, Y.

BOX 151, MT. SAVAGE, MD.

Y7:293

214-02-2003 SACRED HEART HOSPITAL-2003 SECTION OF CHURCH

22. Peter & Paul Computer Accounting Corporation, 44

5071 S. (H)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

00014										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00014																													
1. DECEASED-NAME (Type or Print)										First Middle Last										2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year										2b. HOUR																			
JOHN CALVIN COOK																				Jan. 6. 1969										11p M																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD										2d. HOUR																					
MALE			WHITE			JULY 18, 1887			81 YRS.			MONTHS DAYS			HOURS MIN.			January 8, 1969										11p M																					
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.									
Penns.										USA																				Allegany																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																			
Cumberland										Memorial Hospital-DOA										Retired Brakeman										Railroad																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER									
Md.										Allegany										Rawlings										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										Route 6									
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																			
Theodore Cook																				Mary Ellen Tipton																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
no																				Mrs. Regina Cook, Rawlings, Md.-Wife																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a)										Coronary Occlusion										Sudden																													
4109										DUE TO, OR AS A CONSEQUENCE OF										Coronary Sclerosis										--																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																													
(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
										19																																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																																	
ACTUAL SIGNATURE										BENEDICT SKITARELIC, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED																			
EXAMINER'S NAME (Type)																				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										January 6, 1969																			
																				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																			
Burial										Jan. 9, 1969										Hyndman Cemetery										Hyndman, Penna.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. RECEIVED BY REGISTRAR										25b. RECEIVED BY REGISTRAR																			
James F. Scarpelli, Cumberland, Md.																				JAN 9 1969																													

00014

1900

January 6, 1900

Albany

1900

Retired State

Memorial Hospital

Comptroller

Route 2

Albany

Albany

Very truly yours

Thomas C. Cook

Mrs. Nathan Cook, Albany, N.Y.

Albany

Comptroller

Comptroller

January 6, 1900

Albany

Very truly yours

1900

Albany

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00015										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00015																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First MIDDLE Last NELLIE G. CRITES										JANUARY Month 6 Day Year 69										12:40																			
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 1-23-10										6. AGE (In years last birthday) 98									
7a. BIRTHPLACE (State or foreign country) W. VA.										7b. CITIZEN OF WHAT COUNTRY? USA										B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY									
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give home address) MEMORIAL HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Associated With Husband										12b. KIND OF BUSINESS OR INDUSTRY Transfer									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.										13b. COUNTY ALLEGANY										13c. CITY OR TOWN CUMBERLAND										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
14. FATHER'S NAME First Middle Last CALVIN TURNER										15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE GROVES										13e. STREET AND NUMBER 1114 MICHIGAN AVE.																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) no										16b. SOCIAL SECURITY NO.										17. INFORMANT Address MEMORIAL HOSP. CUMBERLAND, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adrenal cortical</u> 1940 DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Left) Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma as stated above</u>										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-14-1968</u> , to <u>1-6-1969</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>1-5-1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.																																							
22b. SIGNATURE <u>W. F. Williams</u>										22c. DATE SIGNED 1-6-69										22d. PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M. D.										22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 8, 1969										23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park										23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.									
24. FUNERAL DIRECTOR SCARPELLI										ADDRESS FUNERAL HOME, CUMBERLAND, MD.										25a. REC'D BY REGISTRAR JAN 9 1969										25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>									

00015

STATE OF MARYLAND

00131

WILLIE G. CRITES JANUARY 6

REAR WHITE 1 23 19

P. VA. USA X ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL

NO. 10 ALLEGANY CUMBERLAND X 1114 HIGHWAY AVE.

CALVIN TURNER WYLLIE GROVE

MEMORIAL HOSP. CUMBERLAND, MD.

[Handwritten signature]

W. F. WILLIAMS, M. D. 102 S. CENTRE ST., CUMBERLAND, MD.

Jan. 2, 1963 Willard Dental and Orthodontic, etc., etc.

SCARBELL FUNERAL HOME, CUMBERLAND, MD. Jan. 9, 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15-1
45M - 1969

00016										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00016																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										HOUR MIN																																							
WALTER HAROLD CUTCHALL										1 30 69										12:50 PM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS HOURS MIN									
MALE										WHITE										6/20/98										70 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
WEST VIRGINIA										UNITED STATES																				ALLEGANY																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										SACRED HEART HOSPITAL										TEXTILE Mechanic										CELANESE MFG.																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										Chesaptown																				Howard St.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
CURT CUTCHALL										Artima Cunningham																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (If yes give war or dates of service) NO										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
										217 10 4973										SACRED HEART HOSPITAL										900 SETON DRIVE CUMBERLAND, MD.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
4109										IMMEDIATE CAUSE (a) CARDIAC ARREST																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) MASSIVE ACUTE MYOCARDIAL INFARCTION																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c) ARTERIOSCLEROSIS																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1969, to 1-30, 1969, that (I) (we) last saw the deceased alive on 1/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Clarence J. Vincent MD										1/31/69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
CLARENCE VINCENT, MD.										912 SETON DRIVE, CUMBERLAND, MD. 21502																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										2/2/1969										Restlawn Memorial Gardens										Cumberland, Allegany Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
H. Wayne George										21502										FEB 3 1969										W. L. Jones																													
GEORGE FUNERAL HOME										202 GREENE ST., CUMB.,																																																	

00010

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13:20

WALTER WHITE CUTCHILL

W/LE WHITE X
WEST VIRGINIA UNITED STATES
ALLEGANY

CUTCHILL/D SUGRED HEART HOSPITAL TEXTILE WORKS CHINESE HR.
ALLEGANY X X

CUTCHILL/D SUGRED HEART HOSPITAL
CUTCHILL/D SUGRED HEART HOSPITAL
CUTCHILL/D SUGRED HEART HOSPITAL

ARTERIOSCLEROSIS
MASSIVE ACUTE MYOCARDIAL INFARCTION
CARDIAC ARREST

1-30 1-20 1-30 1-30

CLARENCE VINCENT, MD. 012 SETON DRIVE, CUTCHILL/D, NO. 21502
GEORGE FUNERAL HOME 302 GREENE ST., CUTCHILL/D, NO. 21502
CLARENCE VINCENT, MD. 012 SETON DRIVE, CUTCHILL/D, NO. 21502

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

00017				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00017			
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR P			
GLADYS K. DANIELS				1969 JANUARY 15, 1968				12:08M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		AUGUST 22, 1909		59 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				ALLEGANY Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACKED HEART HOSP.		HOUSEWIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				132 BEDFORD ST.			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last									
HENRY TWIGG		(MORRISON) GERTRUDE TWIGG									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
NO		214-09-8184		HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5609										3 DAYS	
DUE TO, OR AS A CONSEQUENCE OF MESENTERIC THROMBOSIS, EXTENSIVE										3 DAYS	
DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE										7 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RHEUMATIC HEART DISEASE, CARDIOMEGALY, AURICULAR FIBRILLATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
1-14-69		INTESTINAL OBSTRUCTION		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. NONE Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
NONE		NONE		NONE							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
NONE		NONE		AUG. 8, 1957, to JAN. 15, 1969							
22a. I certify that (I) (this hospital) attended the deceased from AUG. 8, 1957, to JAN. 15, 1969, that (I) (we) last saw the deceased alive on JAN. 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 12:10 P.M.											
22b. SIGNATURE		22c. DATE SIGNED									
James P. Hallinan		1-17-69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
JAMES P. HALLINAN, M.D.		140 BEDFORD ST., CUMBERLAND, MD. 21502									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		1/18/1969		HILLCREST BURIAL PARK CUMBERLAND, MD.							
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
BYRON KIGHT		CUMBERLAND, MD.		JAN 21 1969							

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700. 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 84

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00018

CERTIFICATE OF DEATH

00018

1. DECEASED-NAME (Type or print) PATIENCE GINN DANIELS			2a. DATE OF DEATH January 15 1969			2b. HOUR 8:23 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH February 10, 1875		6. AGE (In years lost birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.				
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 113 Grand Ave.	
14. FATHER'S NAME First Middle Last Samuel Ginn			15. MOTHER'S MAIDEN NAME First Middle Last ANNIE Annie Marker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Edward Nield Cumberland, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 yrs 10 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June, 1950 to Jan 15, 1969 , that (I) (we) lost saw the deceased alive on Jan 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Clay E. Durrett DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 1/17/69					
22d. PHYSICIAN'S NAME (Type) Clay E. Durrett, Md.					22e. ADDRESS 236 Virginia Ave., Cumb., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 18, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City or Town) (County) (State) Fort Ashby, Mineral, W. Va.				
24. FUNERAL DIRECTOR ADDRESS Philip B. Wendt 121 Memorial Ave., Cumb., Md.				25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

81008

81008



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00019

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00019

1. DECEASED-NAME (Type or Print)			First William			Middle Lowdermilk			Last Darrow			2a. DATE KNOWN OF DEATH Month Day Year 1-19-69				2b. HOUR 11:30p	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-9-1896		6. AGE (In years lost birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year January 19, 1969				2d. HOUR 2:00p	
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany				Md.	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 822 Columbia Avenue								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Employee-Celanese Corp				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 822 Columbia Avenue					
14. FATHER'S NAME First Middle Last Samuel Darrow						15. MOTHER'S MAIDEN NAME First Middle Last Bessie Ellen Lowdermilk											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				(If yes give war or dates of service) WWI				16b. SOCIAL SECURITY NO. 214-07-5823		17. INFORMANT Mrs. Janet Darrow				ADDRESS 822 Columbia Ave Cumberland, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Generalized 153.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of ascending colon DUE TO, OR AS A CONSEQUENCE OF with Lung Metastasis (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																	
19a. DATE OF OPERATION December 1968						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Carcinoma of right colon						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						22b. DATE SIGNED January 19, 1969					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/22/69		23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park				23d. LOCATION (City or Town) (County) (State) Frostburg Allegany Maryland							
24. FUNERAL DIRECTOR Silcox-Merritt Funeral Service						ADDRESS Cumberland, Md				25a. REC'D BY REGISTRAR DATE JAN 23 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

21004

DE : 1988-08-26

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00020

00020

1. DECEASED-NAME (Type or print) HENRY L. DAVIS			2a. DATE OF DEATH Month 01 Day 03 Year 69		2b. HOUR A 2:50M
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH 11-29-09		6. AGE (In years last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during last week, or like work when if retired.) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY COAL CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY ALLEGANY	13c. CITY OR TOWN CUMBERLAND	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 220 FULTON STREET	
14. FATHER'S NAME First Middle Last HENRY DAVIS		15. MOTHER'S MAIDEN NAME First Middle Last (LILLY) GRACE DAVIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-10-6809	17. INFORMANT Address MD. 21502 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 31, 1968 to Jan 3, 1969 , that (I) (we) last saw the deceased alive on Jan 3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wayne C S Peigle M		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-5-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.					
24. FUNERAL DIRECTOR HAFER FUNERAL HOME-230 BALTIMORE AVE., CUMB.,		25a. REC'D BY REGISTRAR MDAN 8 1969		25b. REGISTRAR'S SIGNATURE Charles Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 1-5-69

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DAVIS

L.

HENRY

29

11-29-09

NEGRO

MALE

X

ALLEGANY COUNTY,

U.S.A.

NORTH CAROLINA

COAL CO.

TRUCK DRIVER

SACRED HEART HOSPITAL

CUMBERLAND

220 FULTON STREET

CUMBERLAND X

ALLEGANY

MARYLAND

DAVIS

GLACE

(LILLY)

DAVIS

HENRY

NO. 2102

217-10-2009 SACRED HEART HOSPITAL, 200 SETON DR., CUMBERLAND, MD.

NO

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00021

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00021

1. DECEASED-NAME (Type or Print)			First Anna	Middle Brenice	Last Dawson	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year Jan. 17, 1969			2b. HOUR 5:15 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH March 9, 1893		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Jan. 17, 1969		2d. HOUR 5:15 P.M.		
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 207 So. Lee St.			
14. FATHER'S NAME			First Jeff	Middle ---	Last Martenev	15. MOTHER'S MAIDEN NAME			First Ida	Middle ---	Last Strader
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Daniel M. Dawson,			ADDRESS 207 So. Lee St. Cumb. Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ---									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED Jan. 17, 1969			
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) Rt. # 9 Cumb. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/20/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR H. Wayne George						ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE JAN 21 1969		25b. REGISTRAR'S SIGNATURE H. Wayne George	

THE STATE
HEALTH DEPT.

00021

MEDICAL EXAMINER'S REPORT

00021

Female, white	March 9, 1943	Jan. 17, 1943	Jan. 17, 1943
H. W.	H. S. A.	Alcoholic	Alcoholic
Cambridge, Mass.	U. S. A. Hospital Hosp.	Worcester, Mass.	Cambridge, Mass.
Accountant	Accountant	107 St. Lee St.	107 St. Lee St.
John	John	Ida	Ida
None	None	Mr. Daniel M. Brown, 107 St. Lee St.	Mr. Daniel M. Brown, 107 St. Lee St.

CORONARY OCCLUSION
CORONARY SCLEROSIS

SHOWN

Butler	11/20/49	Second Hospital Recd.	Cambridge, Mass.
H. James George	Cambridge, Mass.	JAN 21 1950	RE. # 9 Camp, Mass.
Jan. 17, 1949	Jan. 17, 1949	RE. # 9 Camp, Mass.	RE. # 9 Camp, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
00022										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
GEORGE			L. DAY			JANUARY Month 3 Day 1969		3:45 M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		12-4-06		62 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. VA.		USA				ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
W. VA.			PAW PAW		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
DAVID DAY			BERTIE MC DONALD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
(If yes give war or dates of service)					MEMORIAL HOSP. CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>arteriosclerotic coronary heart disease</i>										
4123 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<i>Chronic obstructive pulmonary disease</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <i>3 Jan</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3 Jan</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Frederick Miltenberger</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) FREDERICK MILTENBERGER, M.D.					22e. ADDRESS 122 S. GREEN ST., CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		1/6/1969		Camp Hill Cem.		Paw Paw (Morgan) W. Va.				
24. FUNERAL DIRECTOR <i>C. E. Johnson</i>					25a. REC'D BY REGISTRAR <i>W. R. 8</i>		25b. REGISTRAR'S SIGNATURE <i>W. R. 8</i>			
DATE 1/15/69					DATE 1/8/1969					

0824

GEORGE

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DAY

JANUARY

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CUMBERLAND HOSP. CUMBERLAND, MD.

FREEDERICK WILHELMSSON, M.D. 122 S. GREEN ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00023		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00023			
1. DECEASED-NAME (Type or print) First Middle Last REGINA DELANEY						2a. DATE OF DEATH Month Day Year JANUARY 4, 1969		2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 1, 1905		6. AGE (In years lost birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROUTE 1		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CAFETERIA MANAGER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1	
14. FATHER'S NAME First Middle Last WILLIAM S. DELANEY		15. MOTHER'S MAIDEN NAME First Middle Last RACHEL KNIPPENBERG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 214-28-6534		17. INFORMANT Address WM. P. DELANEY, FROSTBURG, MD. 21532					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mos 3 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (1)(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-6- , 19 61 , to 1-4- , 19 69 , that (I) (we) last saw the deceased alive on 1-2- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and on the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph W. Ballin				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-69	
22d. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, M. D.				22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE JAN 8 1969		25b. REGISTRAR'S SIGNATURE W. H. Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 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MIDDLE MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00024 CERTIFICATE OF DEATH 00024									
1. DECEASED-NAME (Type or print) PHILIP			First T.		Middle DICKEL		2a. DATE OF DEATH JANUARY Month 26 , Day 1969		2b. HOUR M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 15, 1908		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D O A MINERS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, specify if retired.) CONSTRUCTION		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN MT. SAVAGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1	
14. FATHER'S NAME First CHARLES Middle E. Last DICKEL			15. MOTHER'S MAIDEN NAME First MARY Middle COLLINS Last COLLINS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 215-10-1258		17. INFORMANT ELMER L. DICKEL, MT. SAVAGE, MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure, irreversible</u> 402X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atrial flutter with complete heart block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic nephritis with azotemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 4, 1969</u> , to <u>Jan 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. Paige Strong</u>		22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.		22e. DATE SIGNED Jan 26, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
00025 CERTIFICATE OF DEATH 00025												
1. DECEASED-NAME (Type or print)			First ROXIE		Middle M.		Last DODGE		2a. DATE OF DEATH 1 Month 26 Day 69 Year		2b. HOUR 12:44 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1-23-99			6. AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.						
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LA VALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10 ASBURY AVENUE				
14. FATHER'S NAME First DANIEL			Middle STULLER		Last (STELLAR)		15. MOTHER'S MAIDEN NAME First MARGARET			Middle STULLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-05-5606		17. INFORMANT HOSPITAL RECORDS			Address 900 SETON DR. CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERIOSCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 64 MIN. ??. ??.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 9-14, 1968 , to 1-26, 1969 , that (I) (we) last saw the deceased alive on 1-26-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>S. G. Weisman</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-26-69				
22d. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.						22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/29/1969		23c. NAME OF CEMETERY OR CREMATORY Crown Crest Memorial Park			23d. LOCATION (City or Town) (County) (State) Clearfield (Clearfield) Penna.					
24. FUNERAL DIRECTOR John H. Haffer		ADDRESS Balto Ave Cumberland		Md.		25a. REC'D BY REGISTRAR Jan 29 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

HOFFER, S. EUGENE; 2104

29 GREENE ST., CAMBRIDGE, MASS.

2. G. WEISMAN, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Items 13a,b,c,d, Film G 409 1/29/69 llw 00026												
00026												
1. DECEASED-NAME (Type or print) First Middle Last James W. Duckworth Sr.					2a. DATE OF DEATH Month Day Year Jan 17 1969			2b. HOUR 4:20 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 10, 1905			6. AGE (In years last birthday) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegheny County Md.			
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegheny County Infirmary			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farming			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE where deceased lived, if institution: Residence before admission STATE West Virginia COUNTY Allegheny			13b. CITY OR TOWN Fort Ashby			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER 1023 Shade's Lane			
14. FATHER'S NAME First Middle Last George Duckworth					15. MOTHER'S MAIDEN NAME First Middle Last Esther Travis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 220-10-2083			17. INFORMANT Address Mrs. Alice Toler, 1023 Shade's Lane						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Chronic obstructive pulmonary disease										not known		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive pulmonary disease										not known		
DUE TO, OR AS A CONSEQUENCE OF (c) Possible carcinoma of lungs & metastasis												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic bronchitis - Mobo paralysis, left following C.V.A. '67.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1969, to Jan 17, 1969, that (I) (we) last saw the deceased alive on Jan 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE John A. Topper M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED Jan 18-1969		
22d. PHYSICIAN'S NAME (Type) John A. Topper M.D.			22e. ADDRESS									
23a. BURIAL, CREMATION, EMBOW (Specify) Burial			23b. DATE 1/20/1969			23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery			23d. LOCATION (City or Town) (County) (State) Fort Ashby, Mineral W. Va.			
24. FUNERAL DIRECTOR Charles E. Hafer			ADDRESS 230 Balto Ave. Cumberland Md			25a. REC'D BY REGISTRAR JAN 21 1969			25b. REGISTRAR'S SIGNATURE Charles E. Hafer			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00027

1. DECEASED-NAME (Type or print) WILBUR			First Middle Last T. DURST			2a. DATE OF DEATH JANUARY Month 29 , Day 1969 Year			2b. HOUR M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH JULY 15, 1887			6. AGE (In years last birthday) 81 YRS.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED FARMER			12b. KIND OF BUSINESS OR INDUSTRY OWN FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 300 E. MAIN STREET			14. FATHER'S NAME First Middle Last NORMAN DURST			15. MOTHER'S MAIDEN NAME First Middle Last ANNIE TURNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO			16b. SOCIAL SECURITY NO. 213-48-6856-T			17. INFORMANT Address ANNA C. DURST, FROSTBURG, MD. 21532					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Art. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 28, 1969 , to Jan 29, 1969 , that we (we) last saw the deceased alive on Jan 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE Leslie R. Miles, M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1.30.69		
22d. PHYSICIAN'S NAME (Type) LESLIE R. MILES, M. D.						22e. ADDRESS STATE ST., LONACONING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 31, 1969			23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY			23d. LOCATION (City or Town) (County) (State) GARRETT COUNTY, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR FEB 3 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

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DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ELMER		G.		FREELAND	JANUARY 3 1969		5:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-26-02		6. AGE (In years last birthday) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) ALLEGANY		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired B & O Carman		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 912 MICHIGAN AVE.
14. FATHER'S NAME First Middle Last PHILIP G. FREELAND		15. MOTHER'S MAIDEN NAME First Middle Last SARAH A. MESSENGER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 705-07-9653		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thrombosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mon 2 mon 3 wks								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1968</u> to <u>Jan 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Charles E. Durrett</u>		22c. DATE SIGNED 1/4/69		22d. PHYSICIAN'S NAME (Type) DR. C.E. DURRETT				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/6/69		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem Gardens		23d. LOCATION (City or Town) (County) (State) LaVale Allegany Maryland		
24. FUNERAL DIRECTOR ADDRESS Silcox-Merritt Funeral Service Cumberland, Md				25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MR. J. A. 4
434-1-69

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ELMER G. FREELAND
WIFE
WHITE
10-26-02
X
USA
ALLEGANY
CUMBERLAND
MEMORIAL HOSPITAL
ALLEGANY CUMBERLAND
112 NICHOLSON AVE.
PHILIP G. FREELAND
1-2-7-72
MEMORIAL HOSPITAL, CUMBERLAND, MD.
JANUARY 3, 1969 2:15 PM

DR. C.E. DORRITT
330 VIRGINIA AVE., CUMBERLAND, MD.
1/2/69
ALLEGANY CUMBERLAND

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 410 MARYLAND STATE DEPARTMENT OF HEALTH
3-7-69 ans Item 21a Film 411 4-14-69 ans

00029

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00029

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
JOSEPH HENRY GOEBEL						JAN. 10, 1969			1:00p M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
MALE	WHITE	AUG. 20, 1912	56 YRS.					Jan. 10, 1969			19 2:00p M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
MARYLAND		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
MT. SAVAGE			MT. SAVAGE			EMPLOYEE GLEN SAVAGE DAIRY FARM					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY			MT. SAVAGE				MT. SAVAGE, MARYLAND	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
WILLIAM GOEBEL			PEARL SHAW								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO						MRS LUCY E. GOEBEL			MT. SAVAGE, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion and edema</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic brain injury</u> (c) <u>Chronic brain injury</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year Evening May 29, 1965			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pulled to ground by a calf and striking his head.					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm			21f. LOCATION Street or R.F.D. No. City or Town County State Mt. Savage Allegany Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D., FACP.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			January 10, 1969					
			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JAN. 14, 1969		LAUREL HILL CEMETERY		MOSCOW MILLS ALLEGANY MD.					
24. FUNERAL DIRECTOR						25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.						JAN 16 1969		<u>Charles Judge</u>			

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00030										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00030																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First WILLIAM										Middle H.										Last GREEN										Month 1 Day 19 Year 69										P.M.																			
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH 9-23-1890										6. AGE (In years last birthday) 78 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U. S. A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ALLEGANY										Md.																			
10. CITY OR TOWN OF DEATH CUMBERLAND										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired.) Laborer										12b. KIND OF BUSINESS OR INDUSTRY Foundry																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ALLEGANY										13c. CITY OR TOWN CUMBERLAND										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER RT. #4, OLDTOWN ROAD.																			
14. FATHER'S NAME First GEORGE										Middle GREEN										Last MARGARET										15. MOTHER'S MAIDEN NAME First CLAUSER										Middle YOUNG										Last GRESS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT Address MEMORIAL HOSPITAL- CUMBERLAND, MD.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease & Congestive Heart Failure (c) Exacerbated Arteriosclerosis of the Heart										DUE TO, OR AS A CONSEQUENCE OF										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from June 16, 1969 to June 19, 1969 , that (I) (we) last saw the deceased alive on June 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE DR. BLANE SCHINDLER										DEGREE MD										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 1/29/69																													
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER										22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan. 22, 1969										23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery										23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																													
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.										ADDRESS										25a. REC'D BY REGISTRAR DATE JAN 21 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00031		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00031	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Joanita</i>			First <i>Joanita</i> Middle <i>Grim</i> Last <i>Grim</i>		2a. DATE OF DEATH Month <i>1</i> Day <i>14</i> Year <i>69</i>		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5-17-1911</i>		6. AGE (In years last birthday) <i>57</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>ALLEGANY</i>	
10. CITY OR TOWN OF DEATH <i>CUMBERLAND</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <i>MARYLAND</i> COUNTY <i>ALLEGANY</i>		13c. CITY OR TOWN <i>CUMBERLAND</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>411 N. MECHANIC ST.,</i>	
14. FATHER'S NAME First <i>VIRGIL</i> Middle <i>CRAWFORD</i> Last <i>HAZEL</i>			15. MOTHER'S MAIDEN NAME First <i>HAZEL</i> Middle <i>HOSPITAL</i> Last <i>KELLER</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>MEMORIAL HOSPITAL - CUMBERLAND, MD.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia with shock</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Kidney failure secondary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>to infected chemical burn right lower leg</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-13-</i> , 19 <i>69</i> , to <i>1-14-</i> , 19 <i>69</i> , that <i>(I)</i> (we) lost the deceased alive on <i>1-13-</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Earl R. Paul</i>					22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <i>EARL R. PAUL</i>					22e. ADDRESS <i>414 N. MECHANIC ST.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<i>BURIAL</i>		<i>JAN. 17, 1969</i>		<i>DAVIS MEMORIAL PARK</i>		<i>CUMBERLAND, MD</i>	
24. FUNERAL DIRECTOR <i>BYRON KIGHT</i>				25a. RECEIVED BY REGISTRAR <i>JAN 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
<i>CUMBERLAND, MD.</i>							

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MEMORIAL HOSPITAL - CUMBERLAND

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NO

BURIAL JAN. 17, 1962 DAVIS MEMORIAL PARK CUMBERLAND, MD

JAN 21 1962

CUMBERLAND, MD.

BYRON KIGHT

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00032										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00032																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
LESLIE M. GROVE										01 04 69										3:35																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
MALE										WHITE										09-09-95										73 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MARYLAND										U.S.A.																				ALLEGANY COUNTY, Md.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. INDUSTRY																													
CUMBERLAND										SACRED HEART HOSPITAL										LABORER										PAPER MILL																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										WESTERNPORT																				420 WALNUT STREET																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
JAMES GROVE										(FAZENBAKER) HARRIETT GROVE																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
YES										W.O.W. 1										217-05-0432										SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:										ADENO-CA OF PROSTATE WITH METASTASES																				1 YEAR																													
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																	
185X																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
																				(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)																																																											
TERMINAL PNEUMONIA																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 12 - 26, 19 68, to 1 - 4, 19 69, that (I) (we) last saw the deceased alive on 1 - 3, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 1 - 4 - 69																													
22d. PHYSICIAN'S NAME (Type)										62 GREENE ST CUMBERLAND, MD. 21502																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										1/7/69										Philos										Westernport (County) Md																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT										MD. 21562										JAN 10 1969										Charles Judge																													

BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT,

MO. 21502

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W. S. SALLIS, D.D.

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217-02-0132

SACRED HEART HOSPITAL, 900 SECON DR., CUMM.

MO. 21502

(FAZENDAKER) HARRIETT

GROVE

JAMES

MARYLAND

ALLEGANY WESTERNPORT X

420 WALNUT STREET

CONDELLAND

SACRED HEART HOSPITAL

LABOREN

PAPER MILL
LUKE

MARYLAND

U.S.A.

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MALE

WHITE

M.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove foran papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
HAROLD			M.		HAISLIP	JANUARY 27 1969			6:45A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		NOV 22, 1903		65			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
W. VA.		USA				ALLEGANY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			MEMORIAL HOSPITAL			RETIRED BALTIMORE AND OHIO EMPLOYEE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MO.			ALLEGANY		CUMBERLAND				906 BRENTWOOD ST.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
GEORGE					HAISLIP	ADA			MARTIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			705-05-5323		MRS ADA LEE HAISLIP 906 BRENTWOOD STREET				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Mc Infirist		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
					Hoke, Frank, Allegany, W.				
22a. I certify that (I) (this hospital) attended the deceased from 1/22/69 to 1/29/69, that (I) (we) lost saw the deceased alive on 1/22/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS					22e. ADDRESS		122 SOUTH CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN 30 1969		DAVIS MEMORIAL PARK		RFD# 4 CUMBERLAND ALLEGANY MD			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
SILCOX-MERRITT 404 DECATUR ST CUMBERLAND MD.					JAN 30 1969		Charles J. Jager		

00033

JANUARY 23 1969 6:15A

HATSLIP

N.

HAROLD

63

JANUARY 23 1969

WHITE

MALE

X

USA

W. VA.

ALLEGANY

MEMORIAL HOSPITAL

CUMBERLAND

900 BRENTWOOD ST.

ALLEGANY CUMBERLAND X

MD.

7-0-55-183

ALLEGANY CUMBERLAND, MD.

ALLEGANY CUMBERLAND, MD.

JAN 30 1969

ALLEGANY CUMBERLAND, MD.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>00034</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>00034</div> <div> <div>2</div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-43. Page 5 may be retained for your files.</div> </div> </div>									
<div> <div>1. DECEASED-NAME (Type or Print)</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>20. DATE KNOWN OF DEATH</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>2b. HOUR</div> <div> <div>12:35p</div> <div>M</div> </div> </div> </div>									
<div> <div>3. SEX</div> <div>Male</div> </div> <div> <div>4. RACE</div> <div>White</div> </div> <div> <div>5. DATE OF BIRTH</div> <div>Mar. 29, 1902</div> </div> <div> <div>6. AGE (In years last birthday)</div> <div>66 YRS.</div> </div> <div> <div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div> </div> <div> <div>IF UNDER 24 HRS.</div> <div>HOURS</div> <div>MIN.</div> </div> <div> <div>2c. DATE PRONOUNCED DEAD</div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>2d. HOUR</div> <div> <div>2:35p</div> <div>M</div> </div> </div> </div>									
<div> <div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div> </div> <div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U S A</div> </div> <div> <div>8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> <div> <div>9. COUNTY OF DEATH</div> <div>Allegany</div> </div>									
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>Cumberland</div> </div> <div> <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Memorial Hospital-DQA</div> </div> <div> <div>12a. USUAL OCCUPATION (Kind of work done during usual of working life, even if retired.)</div> <div>Retired Laborer</div> </div> <div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Allegany Electronics</div> </div>									
<div> <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div> </div> <div> <div>13b. COUNTY</div> <div>Allegany</div> </div> <div> <div>13c. CITY OR TOWN</div> <div>Cumberland</div> </div> <div> <div>13d. INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div> <div> <div>13e. STREET AND NUMBER</div> <div>Route 1, Box 541 Valley Rd.</div> </div>									
<div> <div>14. FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>15. MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div> </div>									
<div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div> <div> <div>16b. SOCIAL SECURITY NO.</div> <div>705-09-5317</div> </div> <div> <div>17. INFORMANT</div> <div>Rosie M Golden, Rte 1, Bx 541, Cumberland, Md</div> </div> <div> <div>ADDRESS</div> <div>Bowmans Addition</div> </div>									
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>CORONARY OCCLUSION</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE</div> <div>4109</div> <div>(b)</div> <div>CORONARY SCLEROSIS</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> </div> <div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>SUDDEN</div> </div> </div>									
<div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> </div>									
<div> <div>19a. DATE OF OPERATION</div> </div> <div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> </div> <div> <div>20. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>									
<div> <div>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div> <div>CAUSE OF DEATH</div> </div> <div> <div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M.</div> <div>P.M.</div> <div>19</div> </div> <div> <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> </div>									
<div> <div>21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></div> </div> <div> <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> </div> <div> <div>21f. LOCATION Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div> </div>									
<div> <div>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div>									
<div> <div>ACTUAL SIGNATURE</div> <div>Benedict Skitarelic</div> <div>M.D.</div> </div> <div> <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> </div> <div> <div>22b. DATE SIGNED</div> <div>January 24, 1969</div> </div> <div> <div>EXAMINER'S NAME (Type)</div> <div>BENEDICT SKITARELIC, M.D.</div> </div> <div> <div>ADDRESS (Street, city, town, or county)</div> <div>CUMBERLAND, MARYLAND</div> </div>									
<div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div> <div> <div>23b. DATE</div> <div>Jan. 27, 1969</div> </div> <div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Sunset Memorial Park</div> </div> <div> <div>23d. LOCATION (City or Town) (County) (State)</div> <div>Near Cumberland Alleg Md</div> </div>									
<div> <div>24. FUNERAL DIRECTOR</div> <div>John J. Hafer, Jr.</div> <div>230 Balto Ave. Cumberland</div> <div>Md.</div> </div> <div> <div>25a. REC'D BY REGISTRAR</div> <div>JAN 27 1969</div> </div> <div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div> </div>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

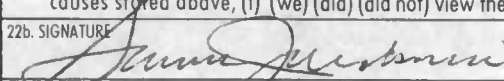

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00035

1. DECEASED-NAME (Type or print)		First MAE	Middle FLORA	Last F. HEADLEY	2a. DATE OF DEATH Month 23 Day 1969 Year		2b. HOUR 3:48A		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1/19/1906		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 32 ROBERTS ST.	
14. FATHER'S NAME First BURTON Middle C. Last APPOLD		15. MOTHER'S MAIDEN NAME First MEADY Middle F. WAGNER Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4249 IMMEDIATE CAUSE (a) Acute Left Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Failure DUE TO, OR AS A CONSEQUENCE OF Coronary Arteriosclerosis (c) Multi valvular disease; Myocardial Fibrosis Over 12 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6hrs. 8yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cholelithiasis, Liver Dysfunction									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1956 , to 1/23/1969 , that (I) (we) last saw the deceased alive on Jan. 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-24-69		
22d. PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON					22e. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS SCARPELLI FUNERAL HOME, CUMBERLAND, MD.					25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE 		

10033

10033

NAME: STONE, F. HEADLEY JANUARY 23 1969 3:40A

FE: WLE WHITE 63

MARYLAND USA ALLEGANY

CUMBERLAND MEMORIAL HOSPITAL

ALLEGANY CUMBERLAND X 32 ROBERTS ST.

BURTON C. APPOLO MEADY F. WAGNER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

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DR. S. M. JACOBSON

50 PERSHING ST., CUMBERLAND, MD.

10033

SCARBELL FUNERAL HOME, CUMBERLAND, MD.

JAN 2 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00036		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00036	
CERTIFICATE OF DEATH						PM	
1. DECEASED-NAME (Type or print) CRAWFORD			First Middle Lost HENDRICKSON			2a. DATE OF DEATH JANUARY 10, 1969	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-6-1897		2b. HOUR 11:20	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (In years last birthday) 71 YRS.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city) MEMORIAL HOSPITAL		9. COUNTY OF DEATH ALLEGANY		12b. KIND OF BUSINESS OR INDUSTRY Maintenance Man	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN LAVALE		13e. STREET AND NUMBER RT. 1 GRAMLICH RD	
14. FATHER'S NAME First Middle Lost WILLIAM HENDRICKSON		15. MOTHER'S MAIDEN NAME First Middle Lost ELLEN SMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		16b. SOCIAL SECURITY NO. WW 1 214-05-6365		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Aneurysm 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crown Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 47 hrs 20 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State Cumberland, Allegany			
22a. I certify that (I) (this hospital) attended the deceased from 1/10/69 19, to 1/10/69 19, that (I) (we) last saw the deceased alive on 1/10/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. J. WILLIAMS				22c. DATE SIGNED 1/12/69			
22d. PHYSICIAN'S NAME (Type) R. J. WILLIAMS				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 1, 1969		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Garden		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR William G. Kight				25a. REGISTERED BY JAN 18 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

0033

CERTIFICATE OF DEATH

0033

CRAWFORD

HENDERICKSON

JANUARY 10, 1962 11:12

MALE

WHITE

2-8-1897

VI

MARYLAND

U. S. A.

X

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

RETIRED ATTENDANCE MAN

MARYLAND

ALLEGANY LAVAL

X

RT. 1 CRAWFORD RD

WILLIAM

HENDERICKSON

ELLEN

SMITH

ON 1

214-05-6362

MEMORIAL HOSPITAL, CUMBERLAND, MD.

R. J. WILLIAMS

132 S. CENTRE ST., CUMBERLAND, MD.

Notary

Cumberland, Md

William G. Nicks

Jan. 1, 1962 Reel Jan. Mem. Garden Cumberland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00037		DIVISION OF VITAL RECORDS, 301 W. PRISTON STREET, BALTIMORE, MARYLAND 21201				00037	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
WILHELMINA				HENDRICKSON	JANUARY 23 1969		2:00A
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	WHITE		6/21/23		45 YRS.	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND	USA				ALLEGANY Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		Housekeeper		At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		625 SCHRIVER AVE.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
ROBERT				SIMONS	HADDIE LANDIS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No		219-14-6806		MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cir of Lung & metastatic to brain</i> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cir of Lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Weak</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>January 1960</i> , to <i>July 23, 1969</i> , that (I) (we) lost the deceased on <i>July 22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		DR. BLANE SCHINDLER		22e. ADDRESS		43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		1/25/69	Sunset Memorial Park		Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SILCOX FUNERAL HOME CUMBERLAND, MD.				JAN 27 1969		<i>[Signature]</i>	

1000

00037

CENTRAL OF DEATH

WILKINSON HENDRICKSON JANUARY 23 1902 3:00A

FEWLE WHITE 072123 ALLEGANY

CUMBERLAND ALLEGANY CUMBERLAND X 022 SCHRIVER AVE

BOUNT STONE BADOLE LANDIS ST-51-506 MEMORIAL HOSPITAL CUMBERLAND, MD

DR. BLANE SCHWILDER 3 GREENE ST., CUMBERLAND, MD.

STILOX FUNERAL HOME CUMBERLAND, MD. 0102 1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1517
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
James Douglas Heron						Month 1 Day 21 Year 1969			8 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		May 23, 1888			80 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
West Va		U.S.A.					Allegany Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland		630 Frederick Street			Retired - C & A Gas Company			Employee	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Cumberland				630 Frederick Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John D Heron			Carrie V Simmons						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. PLACE OF DEATH		
No			314-05-8185A		Martha Lee Heron		630 Frederick Street Cumberland, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis									Sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic vascular disease									Over 5 years
DUE TO, OR AS A CONSEQUENCE OF (c)									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Cerebrovascular accident last of Dec '63									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-31-1963, to 1-21-1964, that (I) (we) saw the deceased alive on 1-17-1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wm. J. Williams				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-22-64			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		1/23/69		Rose Hill Cemetery			Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service				Cumberland, Md		JAN 29 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1289

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00039					00039				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last BEULAH HESS					Month Day Year JANUARY 14 69			6:20 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		8-1-25		43 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL				Gas Sta Operator with Husband			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		OLDTOWN				ROUTE 1	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
HARRY ATHEY			HAZEL SNYDER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No					MEMORIAL HOSPITAL CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u>								3 day	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>interstitial pneumonitis</u>								10 day	
(c) <u>Arteriosclerotic heart disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> , 19 <u>69</u> , to <u>1-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles P. Dross</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-14-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>DR. V. DROSS</u>					22e. ADDRESS <u>1909 FREDERICK ST. CUMBERLAND, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 16, 1969		Sunset Memorial Park		Near Cumberland Alleg Md.			
24. FUNERAL DIRECTOR		ADDRESS		Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Hafer, Jr.		230 Balto Ave Cumberland				JAN 17 1969		<u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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DECEASED BEULAH JANUARY 14 1909

SEX FEMALE RACE WHITE AGE 25-1-35

PLACE OF BIRTH ALABAMA

DECEASED AT MEMORIAL HOSPITAL

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SIGNATURE OF PHYSICIAN

DATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
HERLEN			NEWTON	HOLLER		Month	Day	Year	1:20 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		03-08-04		64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY, Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			CEMENT MASON			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
PENNSYLVANIA			BOYNTON						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
NEWTON			HOLLER			(STEELE) MARY			HOLLER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO			206-03-2106		SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,				MD. 21502
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Complete Left Bundle Branch Block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiac Decompensation</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>?</u> <u>3 wks. ?</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Embolus; Antero Septal Infarction Previous to 12/23</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/</u> , 19 <u>69</u> , to <u>1/31/</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/30/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>S.M. Jacobson</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-31-69</u>		
22d. PHYSICIAN'S NAME (Type) S.M. JACOBSON, M.D.					22e. ADDRESS 50 PERSHING ST., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-3-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SALISBURY I.O.O.F.</u>		23d. LOCATION (City or Town) (County) (State) <u>SALISBURY-SOMERSET PA.</u>			
24. FUNERAL DIRECTOR THOMAS FUNERAL HOME, SALISBURY, PENNSYLVANIA					25a. REC'D BY REGISTRAR DATE <u>FEB 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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U.S.A.

PENNSYLVANIA

CONVENT WAGON

SACRED HEART HOSPITAL

CUMSTLAND

BOYNTON

PENNSYLVANIA

HOLLER

(STEELE) MAY

HOLLER

HEWTON

NOV. 21 1904

206-03-2106 SACRED HEART HOSPITAL, 900 SECON DR., CUMST.

NO

20 PERSHING ST., CUMST., MD. 21202

S.H. JACOBSEN, M.D.

THOMAS FRANKLIN HOME, SALISBURY, PENNSYLVANIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00041												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												00041											
1. DECEASED-NAME (Type or print) First Middle Last ANNA May M. HOWDYSHELL												2a. DATE OF DEATH Month Day Year 01 23 69												2b. HOUR 12:50											
3. SEX FEMALE				4. RACE WHITE				5. DATE OF BIRTH 05-09-88				6. AGE (In years last birthday) 80 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				IF UNDER 24 HRS HOURS MIN															
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY COUNTY, Md.																							
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 121 OAK STREET																			
14. FATHER'S NAME First Middle Last FRANK CHAMBERLAIN				15. MOTHER'S MAIDEN NAME First Middle Last Harriet Chadwick																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16b. SOCIAL SECURITY NO. 800 00 6064				17. INFORMANT Address SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 3 YEARS																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LYMPHATIC LEUCEMIA																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from 11 - 4 , 19 58 , to 1 - 23 , 19 69 , that (I) (we) last saw the deceased alive on 1 - 22 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE Ru Ballin M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED 1-23-69																							
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.												22e. ADDRESS 62 GREENE ST., CUMB., MD. 21502																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Jan. 25, 1969				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																							
24. FUNERAL DIRECTOR ADDRESS SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.												25a. REC'D BY REGISTRAR DATE JAN 27 1969				25b. REGISTRAR'S SIGNATURE Alvin S. Judge																			

00041

STATEMENT OF DEATH

00041

02:51 00 23 10 HONOLULU M. ANN

08 02-00-20 WHITE FEMALE

ALLEGANY COUNTY, U.S.A. PENNSYLVANIA

HONOLULU SACRED HEART HOSPITAL CUMBERLAND

121 OAK STREET ALLEGANY CUMBERLAND MARYLAND

HONOLULU CHAIRMAN FRANK

HONOLULU SACRED HEART HOSPITAL, 000 2100 M.D., COND.

2 WEEKS CEREbro-VASCULAR ACCIDENT

3 YEARS OLD

FLUENT IN ENGLISH

1 - 23 11 - 23 1 - 23

1-23-00 F.V. BULLIE, M.D. 23 GREENE ST., CUMBERLAND, M.D. 21505

SCOTTIE FOREMAN HOME, 103 W. AVE., CUMBERLAND, M.D. 21505

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00042

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00042

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Doris			Ann			Huffman			Month Day Year		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Female			White			Aug. 14, 1936			32 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Maryland			USA			NEVER MARRIED			Allegany		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL-DOA			Nurses Aid			Hospital		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Dailey Howdyshell			Marie Slater			no			219-34-5913		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19. DATE OF OPERATION			20. AUTOPSY?		
Mother			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL 805X DUE TO, OR AS A CONSEQUENCE OF (b) (STRUCK BY FREIGHT TRAIN) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			19a. CONDITION FOR WHICH OPERATION WAS PERFORMED?			21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		
						3:45 P.M. 1-10-69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
						Struck by Freight train on RR crossing					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			RR crossing			Crossing-Avirett Ave.			Cumberland, All. Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:			Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE SIGNED			January 10, 1969		
ACTUAL SIGNATURE			Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			ADDRESS (Street, city, town, or county)			Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 13, 1969			Rio Cemetery			Rio, W. Va.		
24. FUNERAL DIRECTOR			25a. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
James F. Scarpelli, Cumberland, Md.			JAN 15 1969			J. Scarpelli					

000043

MEDICAL EXAMINATION REPORT OF DEATH

000043

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HEALTH

DATE

TIME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00043										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00043														
Item 1, Film G409 2/19/69 cac										CERTIFICATE OF DEATH																								
1. DECEASED-NAME (Type or print) First <u>BABY</u> Middle <u>Diana</u> Last <u>GIRL</u> <u>Carol HUGHES</u>										2a. DATE OF DEATH Month <u>JANUARY</u> Day <u>7</u> Year <u>1969</u>										2b. HOUR <u>4:10</u> MIN <u>PM</u>														
3. SEX <u>FEMALE</u>					4. RACE <u>WHITE</u>					5. DATE OF BIRTH <u>1-7-1969</u>					6. AGE (In years last birthday) <u>1</u> YRS. <u>0</u> MONTHS <u>0</u> DAYS					IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN <u>0</u>					IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>									
7a. BIRTHPLACE (State or foreign country) <u>MD.</u>					7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <u>ALLEGANY</u> Md.																			
10. CITY OR TOWN OF DEATH <u>CUMBERLAND</u>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>MEMORIAL HOSPITAL</u>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>None</u>					12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>																			
13a. USUAL RESIDENCE (Where deceased admission) STATE <u>MD.</u>					13b. CITY OR TOWN <u>ALLEGANY</u>					13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13d. STREET AND NUMBER <u>5 MT. VERNON PLACE</u>																			
14. FATHER'S NAME First <u>WILLIAM R.</u> Middle <u>HUGHES</u> Last <u>EASTON</u>					15. MOTHER'S MAIDEN NAME First <u>CAROLINA</u> Middle <u>M</u> Last <u>EASTON</u>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>No</u> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT Address <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>7760</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Meconium Aspiration</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE <u>Robert Brodell</u>					22c. DATE SIGNED					22d. PHYSICIAN'S NAME (Type) <u>DR. ROBERT BRODELL</u>					22e. ADDRESS <u>500 GREENE ST., CUMBERLAND, MD.</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE <u>Jan. 8, 1969</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>					23d. LOCATION (City or Town) (County) (State) <u>Cumberland Allegany Md.</u>																			
24. FUNERAL DIRECTOR <u>William G. Kight</u>					25a. REC'D BY REGISTRAR <u>JAN 10 1969</u>					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>																								

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Number 1 and 2

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00044

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First William			Middle Mason			Last Judy			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year Jan. 27, 1969			2b. HOUR 1:55 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 4, 1894		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year Jan. 27, 1969			2d. HOUR 1:55 P.M.		
7a. BIRTHPLACE (State or foreign country) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany								
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) D. O. A. Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stationary Fireman				12b. KIND OF BUSINESS OR INDUSTRY Potomac Edison					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland,				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 736 Greene St.			
14. FATHER'S NAME First Middle Last George K. Judy						15. MOTHER'S MAIDEN NAME First Middle Last Mary A. Harman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1						16b. SOCIAL SECURITY NO. 217-10-9584			17. INFORMANT ADDRESS Mrs. Violet M. Judy 736 Greene St. Cumb. Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Jan. 27, 1969									
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
ADDRESS (Street, city, town, or county) Rt. # 9 Cumberland, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/30/69		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park,				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						ADDRESS		25a. RECEIVED BY REGISTRAR JAN 30 1969		DATE		25b. REGISTRAR'S SIGNATURE					

3200

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00045		00045									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
KATHERINE		NMI		KERNS	1 Month 11 Day 69 Year		4:25 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		8 26 07		61 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MISSOURI		USA				ALLEGANY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last year of life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND, MD.		SACRED HEART HOSPITAL		HOUSEWIFE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND				212 CECILIA STREET			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
PHILLIP		CAMPBELL			ELIZABETH (MOBLEY)		CAMPBELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		300 SETON DRIVE		CUMBERLAND, MD.	
NO		NONE		HOSPITAL RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1820		Cancer of endometrium with				1 year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		6 months					
		abdominal metastatic cancer									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
1967		cancer of endometrium									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-1, 1967, to 1-11-1969, that (I) (we) lost saw the deceased alive on 1-10-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
H. Brings MD		1-12-69		DR. LEWIS BRINGS		57 GREENE STREET -CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JAN. 14, 1969		SUNSET MEMORIAL PARK		CUMBERLAND, MD.					
24. FUNERAL DIRECTOR		25a. RECEIVED BY REGISTRAR		25b. RECEIVED BY REGISTRAR		25c. RECEIVED BY REGISTRAR					
KIGHT'S FUNERAL HOME		MAN 10 1969									
309 DECATUR											

RIGHT'S FUNERAL HOME - 309 DECATUR - CUMBERLAND, MD. 21031
 PHILLIP CAMPBELL
 27 GREENE STREET - CUMBERLAND, MARYLAND

NO. LEWIS DRIVING
 HOSPITAL RECORDS
 PHILLIP CAMPBELL
 ELIZABETH (JOSEY) CAMPBELL
 300 SETON DRIVE
 CUMBERLAND, MD.

MA YLANO ALLEGY CUMBERLAND X 212 CECILIA STREET
 CUMBERLAND, MD. SACRED HEART HOSPITAL HOUSEWIFE
 MISSOURI USA X
 FEMALE WHITE 20 07 01
 ALLEGY

KATHERINE III KENNIS I 11 09 1:25P
 10045
 CUMBERLAND, MD. 21031

00046

CERTIFICATE OF DEATH

00046

1. DECEASED-NAME (Type or print)		First WILLIAM		Middle M.	Last KESNER	2a. DATE OF DEATH Month 25 , Day 1969 , Year		2b. HOUR 11:35 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2-5-1922-2-5-22		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carman		12b. KIND OF BUSINESS OR INDUSTRY B & O R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 523 FRANK'S LANE	
14. FATHER'S NAME First CHARLES Middle KESNER Last MARY		15. MOTHER'S MAIDEN NAME First L. Middle RODEHEAVER Last RODEHEAVER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes (If yes give war or date of service) War II-LK		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Left Lung with Metastases</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23-69</u> , 19____, to <u>1-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-25-69</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Calvin Y. Hadidian</u>		DEGREE DR. CALVIN Y. HADIDIAN		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-28-69			
22d. PHYSICIAN'S NAME (Type) DR. CALVIN Y. HADIDIAN		22e. ADDRESS 203 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 29, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 4 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00043

CERTIFICATE OF DEATH

00043

DEATH CERTIFICATE OF DEATH

RESIDENCE

M.

WILL

JANUARY 22, 1968

11:32

2-3-1923-5-55

WHITE

MALE

X

U. S. A.

HAWAII

ALLEGANY

MEMORIAL HOSPITAL

CONDON

X

CONDON

ALLEGANY

CONDON

MARY

KESNER

CHARLES

MEMORIAL HOSPITAL, CONDON, WY.

WYOMING

505 FRANK'S LAKE

ROCHESTER

CONDON, WY.

505 GREENE ST., CONDON, WY.

DR. CALVIN Y. MAGUIAN

CONDON, WY.

CONDON, WY.

CONDON, WY.

CONDON, WY.

CONDON, WY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
00047										
Item 6 Film 408 1/13/69 kk										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
CHARLES V KIFER						JANUARY 5 1969		3:15		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
MALE		WHITE		8-12-1899		69 69 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
PENNA.		USA				ALLEGANY COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			MD. WORKSHOP FOR BLIND				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		913 GRAND AVE.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JOHN KIFER			MARGARET FAHEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No					MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> <u>4300</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1 yr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>69</u> , to <u>1/5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1/5</u> , 19 <u>69</u> , and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/6/69</u>			
22d. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN					22e. ADDRESS <u>59 GREENE ST., CUMBERLAND, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Jan. 8, 1968		St. Mary's Cemetery		Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.					DATE <u>1/9</u> 1969		<u>[Signature]</u>			

VR 415-74
6-10-69

00647

CERTIFICATE OF BIRTH

CHARLES R. KIRBY
 JANUARY 21 1980
 WHITE
 8-12-1989
 ALLEGANY COUNTY
 ALLEGANY COUNTY
 HOSPITAL
 ALLEGANY COUNTY
 212 GRAND AVE.
 KIRBY
 MARGARET
 KIRBY
 HOSPITAL, CUMBERLAND, MD.

DR. S. G. WEISMAN
 22 GREENE ST., CUMBERLAND, MD.
 6, 1988
 1988
 CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A.M. P.M.	
CATHERN			ANGELLA KLINK			Month 01 Day 08 Year 69		12:50 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost by day)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		09-18-03		65 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLEGANY COUNTY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
PENNSYLVANIA			MEYERSDALE				RT. #4, BOX 238		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
PATRICK LUDDEN			(BRODENICK) CATHERYNE LUDDEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			162-16-5638		SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>244X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myxedema and RHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Embolism</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D. M. Kauffman M.D.</u>					22c. DATE SIGNED <u>1-8-69</u>		22d. PHYSICIAN'S NAME (Type) M. KAUFFMAN, M.D.		
22e. ADDRESS <u>912 SETON DRIVE, CUMB., MD. 21502</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		1/11/69		SS PHILIP JAMES CEME		MEYERSDALE Som Co. PA			
24. FUNERAL DIRECTOR <u>M. R. Zerkow</u>					25a. REC'D BY REGISTRAR <u>JAN 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
PRICE FUNERAL HOME, MEYERSDALE, PENNSYLVANIA									

PRICE FUNERAL HOME, MEYERSDALE, PENNSYLVANIA

M. KAUFFMAN, M.D.

312 SET N DRIVE, COMB., MD. 21202

NO

102-16-2536

SACRED HEART HOSPITAL, 900 SETON DR., COMB., MD. 21202

PATRICK

LUDELL

(GRODENICK) CATHERINE

LUDELL

PENNSYLVANIA

MEYERSDALE

RT. 44, BOX 230

CONSERVATION

SACRED HEART HOSPITAL

HOSPITAL

PENNSYLVANIA U.S.A.

ALLEGANY COUNTY

FEMALE

WHITE

00-19-03

65

CATHERINE

ANGELLA

KLINK

01

00 09 12:50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00049		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00049			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Sarah			First Middle Last Mae Kriglein			2a. DATE OF DEATH @ 4:45 P.M. January 22, 1969		2b. HOUR P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/14/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany County Md.			
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany County Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 306 Auburn Avenue	
14. FATHER'S NAME First Middle Last Mathew Schaffer			15. MOTHER'S MAIDEN NAME First Middle Last Catherine Heiland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no		16b. SOCIAL SECURITY NO. 220-10-9151		17. INFORMANT P.O.Box 599, Address: Cumberland, Md.		DI Allegany County Infirmary records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4369 DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from August 13, 1968, to Jan 22, 1969, that (I) (we) last saw the deceased alive on 1/21/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George M. Simons, M.D.				DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/22/69			
22d. PHYSICIAN'S NAME (Type) George M. Simons, M.D.				22e. ADDRESS Memorial Hospital, Cumberland, Md. 21502					
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE Jan. 25, 1969		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 27 1969		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First NORENE		Middle E.		Last LARKIN		2a. DATE OF DEATH Month 01 Day 18 Year 69	
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH 11-02-91			6. AGE (In years last birthday) 77 YRS.		2b. HOUR 2:00 M
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT#2, BOX 203, FROST., MD.	
14. FATHER'S NAME First WILLIAM			Middle HENCKEL		Last (LOGSDON) EMMA			15. MOTHER'S MAIDEN NAME First HENCKEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 217-54-6820		17. INFORMANT Address 21502 SACRED HEARTHOSPITAL, 900 SETON DR., CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) LEFT VENTRICULAR FAILURE										
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE										
DUE TO, OR AS A CONSEQUENCE OF										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) INFLUENZA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State (69)					
22a. I certify that (I) (this hospital) attended the deceased from 12 DECEMBER 19 68 , to 1 - 18 , 19 68 , that (I) (we) last saw the deceased alive on 1 - 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.W. Ballin M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-19-69			
22d. PHYSICIAN'S NAME (Type) R.W. BALLIN, M.D.					22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-21-69		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICK'S CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE MD.				
24. FUNERAL DIRECTOR DURST FUNERAL HOME, 57 FROST AVE., 68 FROST.					25a. JAN 23 1969		25b. REGISTRAR'S SIGNATURE			

DUST FULLER L HOME, 57 FROST AVE., DC FROST.

NO. 21502

W. W. BULLIN, M.D. 62 GREENE ST., CUMBERLAND, MD. 21502

1-1949

X

128621 FR. 1 - 18 (2)

1 - 18

X

INFLUENZA

INTERIOSTEROIC CARDIO-VASCULAR DISEASE

LEFT VENTRICULAR FAILURE

217-54-8-205468 HEADHOSPITAL, 900 SETON DR., MD. 21502

WILLIAM HENCKEL (LEGSDON) BMM HENCKEL

MARYLAND ALLEGANY FROSTBURG 1712, BOX 203, FROST, MD.

CUMBERLAND SAGGED HEART HOSPITAL

MARYLAND U.S.A. X ALLEGANY COUNTY,

FEMALE WHITE 11-02-91 77

MORENO E. LARKIN 01-18-89 2:00

00050

00050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00051										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00051																																																											
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																											
JOHN FRANCIS LEEDY										Month 01 Day 04 Year 69										11:55 PM																																																											
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
MALE										WHITE										06-24-96										72 YRS.										MONTHS										DAYS										HOURS										MIN.									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																																							
PENNSYLVANIA										U.S.A.																				ALLEGANY COUNTY,																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
CUMBERLAND										SACRED HEART HOSPITAL										Ret. Truck Driver										RAILROAD																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																																							
MARYLAND										ALLEGANY										CUMBERLAND										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										216 S. LEE STREET																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
First Middle Last										First Middle Last																																																																					
JAMES LEEDY										(OSBORNE) ELIZABETH LEEDY																																																																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
NO										714-05-6814										SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,										MD. 21502																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART 1. DEATH WAS CAUSED BY:																																																																															
IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u>																																																																															
5719										DUE TO, OR AS A CONSEQUENCE OF																				20 day																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) <u>Advanced Carcinoma of Liver</u>																				6 mos.																																																	
										(c) <u>& Anasarca</u>																																																																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
										HOUR A.M. Month Day Year P.M. 19																																																																					
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION																																																											
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																				Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>68</u> , to <u>11/7/69</u> , that (I) (we) last saw the deceased alive on <u>11/4/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																																	
																														11/7/69																																																	
22d. PHYSICIAN'S NAME (Type)										22b. ADDRESS																																																																					
J.A. PAGAN, M.D.										1068 NATIONAL HWY., LA VALE, MD. 21502																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										11/7/69										SS. Peter & Paul's Cem.										Cumberland, Allegany, Md.																																																	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
H. Wayne George										GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD.										JAN 9 1969										Charles Judge																																																	

GEORGE FUNERAL HOME, 202 GREENE ST., COB., MD. 21030
 J.A. PAGA, M.D., 100 NATIONAL HWY., LA VALL, MD. 21020

714-05-0014 SACKED HEART HOSPITAL, 300 SECH DR., COB., MD. 21030

JAMES LEEDY (OSBORNE) ELIZABETH LEEDY

MARYLAND ALLEGANY CUMBERLAND X 216 S. LEE STREET

CUMBERLAND SACKED HEART HOSPITAL

PENNSYLVANIA U.S.A. X

WHITE 00-24-90 75

JOHN F. LEEDY 01 04 22:11:22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First JOSEPH		Middle G.		Last LEWIS		2a. DATE OF DEATH Month Day Year JANUARY 15th, 1969		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 1ST, 1899			6. AGE (In years last birthday) 69 YRS.		2b. HOUR 4:54 PM		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH FROSTBURG,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINER'S HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE			12b. KIND OF BUSINESS OR INDUSTRY W. MD. R. R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 STOYER STREET,		
14. FATHER'S NAME First Middle Last THEOPHILUS LEWIS			15. MOTHER'S MAIDEN NAME First Middle Last IDA GEARY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 217-03-1605		17. INFORMANT MRS. ELIZABETH LEWIS,			Address FROSTBURG, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial ischemia</u> 12 yrs. (c) <u>Coronary arteriosclerosis</u> 12 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Emphysema, moderately severe</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 11, 1969</u> , to <u>Jan. 15, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Alvin J. Walters</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/17/69</u>			
22d. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS,						22e. ADDRESS 48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 1-18-69		23c. NAME OF CEMETERY OR CREMATORY FBC. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532						25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

00028

00028

CHINA AIR FORCE

JAN 20 1963

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with other pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00053

1. DECEASED NAME (Type or Print) Ronald Young Lehr, Sr.			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year Jan. 31, 1969			2b. HOUR 4:40p M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1/1/1912	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year January 31, 1969 19 4:40p M		
7a. BIRTHPLACE (State or foreign country) Spokane Wash.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Conductor		12b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Flintstone		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Flintstone Rt #2
14. FATHER'S NAME First Middle Last Peter Young Lehr			15. MOTHER'S MAIDEN NAME First Middle Last Rose Dawson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ronald Y. Lehr Sr.		ADDRESS Flintstone Rt #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Thrombosis, Left DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden " ---
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Benedict Skitarellic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED January 31, 1969		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, or REMOVAL (Specify) Removal		23b. DATE 2/4/68		23c. NAME OF CEMETERY OR CREMATORY Davis Memo. Pk.		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany MD		
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.				25. REC'D BY REGISTRAR FEB 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)
45M 1/69

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00054 CERTIFICATE OF DEATH 00054									
1. DECEASED-NAME (Type or print) MICHAEL HUMBIRD LONG					2a. DATE OF DEATH Month 1 Day 2 Year 69				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-25-1888			6. AGE (In years last birthday) 80 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Own Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE #4,
14. FATHER'S NAME First MICHAEL Middle LONG Last LONG			15. MOTHER'S MAIDEN NAME First SALLIE Middle STICKLEY Last STICKLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) 3 years									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Jan 1, 1967 , to 2 Jan, 1969 , that (1) (we) lost the deceased alive on Jan 1, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Frederick Miltenberger					22c. DATE SIGNED 4 Jan 69		22d. PHYSICIAN'S NAME (Type) DR. FREDERICK MILTENBERGER		
22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

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LONG

MICHAEL

STICKLEY

MEMORIAL HOSPITAL-CUMBERLAND, MD.

DR. FREDERICK WILFREDER 122 S. CENTRE ST., CUMBERLAND, MD.

General Hospital, Cumberland, Md.
General Hospital, Cumberland, Md.
General Hospital, Cumberland, Md.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Joseph			Middle Michael			Last Malamphy			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Year 1-14-69			2b. HOUR 4:00 a M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 24, 1924		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month January Day 14, Year 1969			2d. HOUR 4:00 a M		
7a. BIRTHPLACE (State or foreign country) W. Va.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer,				12b. KIND OF BUSINESS OR INDUSTRY Town of Ridgeley, W. Va.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va.				13b. COUNTY Mineral				13c. CITY OR TOWN Ridgeley,				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Knobley Rd.			
14. FATHER'S NAME First John Middle M. Last Malamphy				15. MOTHER'S MAIDEN NAME First Anna Middle M. Last Troll													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes,				16b. SOCIAL SECURITY NO. W.W. #1, Korean 233-34-5494				17. INFORMANT ADDRESS Mrs. Anna M. Malamphy Knobley Rd. Ridgeley, W. Va.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY THERMAL BURNS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 890 X (b) (CONFLAGRATION OF DWELLING) DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Hours 10 Hours																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR 6:00 P.M. 1-13-69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Trapped in burning dwelling									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ RIDGELEY, MINERAL, WEST VIRGINIA									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED XX JANUARY 14, 1969					
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/17/69		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.							
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						25a. REC'D BY REGISTRAR DATE JAN 17 1969				25b. REGISTRAR'S SIGNATURE Charles Judge							

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PAGE 27 continued

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00056											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) ALFRED						2a. DATE OF DEATH JANUARY 23, 1969		2b. TIME OF DEATH 5:50 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-10-1875		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give name of place where death occurred) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of life or last life, even if retired.) RETIRED - custodian		12b. KIND OF BUSINESS OR INDUSTRY Tire Industry			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 20 WRIGHT'S AVE., GREEN BOWLING			
14. FATHER'S NAME BUCKNER				15. MOTHER'S MAIDEN NAME CLARA WILBURN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 220-10-8749		17. INFORMANT MEMORIAL HOS PITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) carcinomatosis											
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Prostate											
DUE TO, OR AS A CONSEQUENCE OF (c) 185 X											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) A.S. Cardiovascular disease with gen. arteriosclerosis 10 years											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on 23 Jan. 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. A. Van Normer, M.D.						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) DR. W. A. VANORMER						22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/26/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.						25a. REC'D BY REGISTRAR JAN 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

00822

PM
2:50

JANUARY 23, 1953

BLISS WASON

ALFRED

33

6-10-1912

WHITE

MALE

ALLEGANY

X

U. S. A.

MARYLAND

MEMORIAL HOSPITAL

CUMBERLAND

RETIRED - DR. JAMES

ALLEGANY CUMBERLAND X

MARYLAND

WASON

CLARA

BUCKNER

WILBURN

720-10-2711

MEMORIAL HOSPITAL

CUMBERLAND, MD.

DR. W. A. VANORNER

122 S. CENTRE ST., CUMBERLAND, MD.

1755123
Hilcox & Sons, Inc.
Cumberland, Maryland
U. S. Army, Cumberland, Md.

Cumberland, Maryland, Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00057

00057

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Francis Joseph McDade						Jan. 3, 1969			M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	July 9, 1904	64 YRS.	5 24				Jan. 3, 1969	M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Frostburg, Md.		U.S.A.				Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
McCoole			Route 220			Retired Trackman		B. & O. R.R.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.			Allegany		McCoole.		Box 13 B		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Charles McDade			Ellen Begley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS				
No					R.F.D. 3 Box, 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)			CORONARY OCCLUSION			SUDDEN			
CORONARY SCLEROSIS			--						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 1-3-69			
ACTUAL SIGNATURE <i>Benedict Skitarellic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1-7-69		St. Thomas Cem.		Keyser, W. Va. Mineral			
24. FUNERAL DIRECTOR <i>Harold W. McKenzie</i>			ADDRESS Keyser, W. Va.			25a. REC'D BY REGISTRAR DATE JAN 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

72027

2-4

Journal of Management Inquiry 16(4)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00058

1. DECEASED-NAME (Type or Print)			First Mark			Middle Allen			Last Mechem			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 1-21-69 12:30a.m.			2b. HOUR		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 3, 1968		6. AGE (In years last birthday) 0 YRS.		IF UNDER 1 YEAR MONTHS DAYS 1 18		IF UNDER 24 HRS. HOURS MIN. 18		2c. DATE PRONOUNCED DEAD Month Day Year January 21, 1969 2:30a.m.			2d. HOUR		
7a. BIRTHPLACE (State or foreign country) Maryland,				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany					
10. CITY OR TOWN OF DEATH Cumberland,						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None, Infant			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 531 Patterson Ave.					
14. FATHER'S NAME Clyde			First D.			Middle Mechem			15. MOTHER'S MAIDEN NAME Mary			First K.			Middle Cornelius		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No,				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. None,				17. INFORMANT Mr. Clyde D. Mechem, 531 Patterson Ave. Cumb.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Congestion and Edema</u> Hours																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) <u>Patent Ductus Arteriosus and Foramen Congenital.</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) <u>Ovale</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 21, 1969						ADDRESS (Street, city, town, county, state) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/23/69				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.					
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland										25a. REC'D BY REGISTRAR DATE JAN 27 1969				25b. REGISTRAR'S SIGNATURE Charles Judge			

00028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
KATHRYN MARIE MICHAELS					1 Month 31 Day 69 Year		9:00 PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE	WHITE		3/31/22		48 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND	USA				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of year, if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		FROSTBURG		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ROUTE 1 -BOX 621	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
WALTER SOLOMAN					MARY ISA SOLOMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		NONE		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u>								4 days	
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Multiple metastatic lesions</u>								2 years	
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Capillary of Kidney</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> , 19 <u>69</u> , to <u>1-31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Robert Feddis</u>									
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DR. ROBERT FEDDIS				500 GREENE STREET -CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/3/69		PORTER CEMETERY		ECKHART, ALLEGANY, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
M. SOWERS		FEB 4 1969		J. SOWERS					
HOME, 60 W. MAIN, FROSTBURG									

2500

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 1/29/69 llw 00060										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										00060																			
1. DECEASED-NAME (Type or Print)					First Middle Last					2a. DATE KNOWN OF DEATH					2b. HOUR														
LEROY					MILLER					Jan. 22 1969					4P M														
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					2d. HOUR												
MALE		WHITE		Sept. 17, 1900		68 YRS		MONTHS DAYS		HOURS MIN.		Month Day Year 1969					5P M												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					9. COUNTY OF DEATH					Md.									
PENNA.					USA										ALLEGANY														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
CUMBERLAND					725 N. Mechanic St.					Retired Fireman					Municipal														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
MD.					ALLEGANY					CUMBERLAND					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					725 N. Mechanic St.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					First Middle Last					First Middle Last														
PERRY					V. MILLER					RUFFINA WHITACRE																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
NO										Mr. Harold Miller, Cumberland, Md.					Brother														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109										CORONARY OCCLUSION										SUDDEN									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										CORONARY SCLEROSIS										---									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
CAUSE OF DEATH					HOUR A.M. P.M. 19																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE					BENEDICT SKITARELIC, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED														
										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					Jan. 22, 1969														
EXAMINER'S NAME (Type)										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					ADDRESS (Street, city, town, or county)														
										CUMBERLAND, MARYLAND																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Jan. 25, 1969					Hyndman Cemetery					Hyndman, Penna.														
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR									
James F. Scarpelli, Cumberland, Md.																				JAN 27 1969									
																				25b. REGISTRAR'S SIGNATURE									

00000

DATE: Jan. 22, 1964
TIME: 10:00 AM
TO: Mr. J. Edgar Hoover
FROM: Mr. J. Edgar Hoover

SUBJECT: [Illegible]
RE: [Illegible]

REFERENCE: [Illegible]

ATTENTION: [Illegible]

NOTES: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

ENCLOSURES: [Illegible]

APPROVED: [Illegible]
SPECIAL AGENT IN CHARGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ISAAC	Middle S.	Last MORELAND	2a. DATE OF DEATH Month 20 Day 19 Year 1969		2b. HOUR 3:10 M M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-19-81		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.		13b. COUNTY MINERAL		13c. CITY OR TOWN RIDGELEY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE #1			
14. FATHER'S NAME			First BASIL	Middle NEWTON	Last MORELAND	15. MOTHER'S MAIDEN NAME			First RHODA	Middle WHITACRE	Last WHITACRE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 236-58-1129		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4124 Congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF (c) dis. years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from 10-18-1968 , to 1-20-1969 , that (I) (we) last saw the deceased alive on 1-19-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W. F. Williams		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-20-69					
22d. PHYSICIAN'S NAME (Type) W. F. WILLIAMS, M. D.		22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 23, 1969		23c. NAME OF CEMETERY OR CREMATORY Levels		23d. LOCATION (City or Town) (County) (State) Levels Hampshire W. Va.					
24. FUNERAL DIRECTOR SHAFFER FUNERAL HOME, ROMNEY, W. VA.				ADDRESS		25a. DEED BY REGISTRAR JAN 24 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

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JANUARY 20 1952 3:10

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CHAMBER FURNERAL HOME, ROMNEY, W. VA.
JAN 24 1952
W. F. WILLIAMS, W. D. 122 S. CENTRE ST., CUMBERLAND, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00062										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00062																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First MIDDLE Last										Month Day Year										HOURS MIN																																							
WILBERT										L. MOWEN										1 7 69 7:20A																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
MALE										WHITE										4-29-83										85 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
PENNSYLVANIA										U.S.A.																				ALLEGANY																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
CUMBERLAND										MEMORIAL HOSPITAL										RETIRED * B & O Employee																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ALLEGANY										FLINTSTONE										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										RT. 2																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First MIDDLE Last										First MIDDLE Last																																																	
DAVID F. MOWEN										VIRGINIA										HOUCK																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
																				MEMORIAL HOSPITAL										CUMBERLAND, MD.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																	
485X										Apert Failure Extension of heart disease																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										Bronchopneumonia																																																	
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Bronchial asthma																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 60, to _____, 19 69, that (I) (we) last saw the deceased alive on _____, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Dr. S. G. WEISMAN										1/8/69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										CUMBERLAND, MD.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										1/9/69										Pleasant Grove Cemetery										Cumberland Allegany Maryland																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Silcox-Merritt Funeral Service, Cumberland, Md																				10 1969										Charles J. J...																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00063		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00063		
1. DECEASED-NAME (Type or print)			First ANNA	Middle MAE	Last NEILSON	2a. DATE OF DEATH Month 01 Day 10 Year 69		2b. HOUR 4:25 M
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-03-95		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of previous 12 months if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 259 WELCH HILL
14. FATHER'S NAME First THOMAS		Middle DAVIS		Last DAVIS		15. MOTHER'S MAIDEN NAME First (EISENTROUT) CLEMMIE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-09-6427		17. INFORMANT SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive arteriosclerotic C. V. H. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 8 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma left breast capillary metastases</u>								
19a. DATE OF OPERATION 12/30/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer left breast		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1968, to 1/10, 1969, that (I) (we) lost saw the deceased alive on 1/9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Thomas F. Lewis M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/11/69
22d. PHYSICIAN'S NAME (Type) T.F. LEWIS, M.D.				22e. ADDRESS 500 GREENE ST., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-12-1969		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK FROSTBURG, ALLEG., MD.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.				25a. REGD. BY REGISTRAR DATE JAN 16 1969		25b. REGISTRAR'S SIGNATURE James Judge		

FIRST FUNERAL HOME, 57 FROST AVE., FROST, MD.

500 GREENE ST., CUMBS, MD. 21025

T.F. LEWIS, M.D.

NC

213-00-2527

SACRED HEART HOSPITAL, 300 SECON DR., CUMBS, MD. 21025

THOMAS

DAVIS

(EIRSTROUT) CLEMIE

DAVIS

MARYLAND

ALLEGANY FROSTBURG

X

259 WELCH HILL

CUNDELRAND

SACRED HEART HOSPITAL

HOUSEWIFE

WEST VIRGINIA

U.S.A.

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ALLEGANY COUNTY,

FEMALE

WHITE

11-03-32

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-65

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
00064																							
1. DECEASED-NAME (Type or print)			First SARA			Middle (WELLINGS)			Last NEILSON			2a. DATE OF DEATH Month JANUARY			Day 3,			Year 1969			2b. HOUR 2:00 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH AUGUST 1, 1908			6. AGE (In years last birthday) 60			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			IF UNDER 24 HRS. HOURS			IF UNDER 24 HRS. MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY														
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROUTE 1			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME														
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER RT. 1, BOX 51											
14. FATHER'S NAME First GEORGE			Middle WELLINGS			Last NEILSON			15. MOTHER'S MAIDEN NAME First JULIA			Middle RAE			Last NEILSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT MARSHALL NEILSON, RT. 1, FROSTBURG, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial fibulation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>12 yrs.</u> <u>18 yrs.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <u>November 1959</u> , to <u>December 12, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Alvin J. Walters MD</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>1/3/68</u>								
22d. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M. D.			22e. ADDRESS 48 BROADWAY, FROSTBURG, MD. 21532																				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 5, 1969			23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.														
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532			ADDRESS			25a. RECORD BY REGISTRAR JAN 7 1969			25b. REGISTRAR'S SIGNATURE <u>John Judge</u>														

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DEPARTMENT OF DEATH

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NAME (Last, First, Middle) _____

DATE OF BIRTH _____

PLACE OF BIRTH _____

DATE OF DEATH _____

CAUSE OF DEATH _____

PLACE OF DEATH _____

DATE OF BURIAL _____

PLACE OF BURIAL _____

NAME OF FUNERAL HOME _____

NAME OF MINISTER _____

NAME OF CHURCH _____

NAME OF CEMETERY _____

NAME OF INTERVIEWER _____

NAME OF WITNESS _____

NAME OF CLERK _____

NAME OF JURY _____

NAME OF JUDGE _____

NAME OF PROSECUTOR _____

NAME OF DEFENSE _____

NAME OF JURY _____

NAME OF JUDGE _____

NAME OF PROSECUTOR _____

NAME OF DEFENSE _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00065		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00065						
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)		First SIMON		Middle P.	Last NEWLIN		2a. DATE OF DEATH Month JANUARY		Day 12, 1969		Year 5:55AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPTEMBER 15, 1876		6. AGE (In years last birthday) 92		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY						
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Guard		12b. KIND OF BUSINESS OR INDUSTRY Electric						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 551 WINIFRED ROAD				
14. FATHER'S NAME First JOHN		Middle Last NEWLIN		15. MOTHER'S MAIDEN NAME First CLARA		Middle Highby		Last HIGBER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-10-9460		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>												
4409 DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>General arteriosclerosis</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Benign hypertrophy of prostate & obstructive</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , to <u>1/12, 1969</u> , that (I) (we) lost saw the deceased alive on <u>1/11, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>S. G. Weisman</u> MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <u>1/14/69</u>												
22d. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN 22e. ADDRESS <u>59 GREENE STREET, CUMBERLAND, MD.</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport, Alleg., Md.						
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave., Cumb., Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 16 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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NAME: SIMON, F.
DATE: SEPTEMBER 12, 1942
RACE: WHITE
SEX: M
BIRTH: JANUARY 15, 1903
ALLEGY: VIRGINIA

CLINICAL HISTORY: ADMITTED TO MEDICAL HOSPITAL, CUMBERLAND, MD.
REASON FOR ADMISSION: ALLEGY - CUMBERLAND, MD.
PHYSICIAN: JOHN NEWLIN
NURSE: CLARA
HOSPITAL: MEDICAL HOSPITAL, CUMBERLAND, MD.

DR. S.C. WEISMAN
30 GREENE STREET, CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) SAMUEL First Middle Last A. NICHOLS					2a. DATE OF DEATH Month 1 Day 1 Year 69 2b. HOUR 11:30 MIN. A.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8-17-1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL - R. Blacksmith H.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 514 WOODSIDE AVE.	
14. FATHER'S NAME First Middle Last BENJAMIN NICHOLS				15. MOTHER'S MAIDEN NAME First Middle Last SARAH MC GEE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 4705-07-9629		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Heart Attack									
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State Cumberland, Allegany Md.					
22a. I certify that (I) (this hospital) attended the deceased from 4/1/69 , 19 69 , to 1/1/69 , 19 69 , that (I) (we) last saw the deceased alive on 1/1/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Williams				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/2/69			
22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS				22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 4, 1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND

CUMBERLAND

MARYLAND ALLEGANY CUMBERLAND X 2TH WOODSIDE AVE.

BENJAMIN NICHOLS SARAH MC GEE

400-00-0000 ME MORTAL HOSPITAL - CUMBERLAND, MD.

DR. H. J. WILLIAMS

122 S. CENTRE ST., CUMBERLAND, MD.

James E.

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
MYRTLE M. OBERLY									1 Month 2 Day 69 Year		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR		
FEMALE		WHITE		4/2/96			72 YRS.		3:00 P M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
WEST VIRGINIA		USA					ALLEGANY		Md.		
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			ALLEGANY		WESTERNPORT				115 GREENE STREET		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
CONNOR SHILLINGBURG			EMMA HALL SHILLINGBURG								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			234 03 2668		SACRED HEART HOSPITAL			900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>coronary artery disease</u>										3 years	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>generalized arteriosclerosis</u>										3 years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-</u> , 19 <u>68</u> , to <u>1-2-</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>1-2-</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
<u>Lewis Brings M.D.</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			1-3-69		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
DR. LEWIS BRINGS			57 GREENE ST - CUMBERLAND, MD. 21502								
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Buried			1/6/69		Pharos			Westernport, Md (State)			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>E. S. Boal</u>			ADDRESS			JAN 10 1969			<u>Charles Judge</u>		
BOAL'S FUNERAL HOME			-111 CHURCH STREET			WESTERNPORT, MD. 21562					

27 GREENE ST - OBERLAND, MO. 65052

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First CHARLES			Middle H.			Last OWENS			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year JAN. 31, 1969			2b. HOUR 11:30		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 18, 1909		6. AGE (in years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year JAN. 31 1969			2d. HOUR 11:30		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA SACRED HEART HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FILTRATION				12b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1							
14. FATHER'S NAME First Middle Last CHARLES H. OWENS			15. MOTHER'S MAIDEN NAME First Middle Last NELLIE CAMPBELL														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-07-4685			17. INFORMANT ADDRESS NELLIE OWENS, RT. 1, FROSTBURG, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalized 197.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of Liver DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Benedict Skitarelic				M.D. BENEDICT SKITARELIC, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type)				22b. DATE SIGNED Jan. 31, 1969				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county) RD 9, CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 2-3-69		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK				23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.							
24. FUNERAL DIRECTOR J. R. DURST, FROSTBURG, MD. 21532						ADDRESS		25a. RECEIVED BY REGISTRAR FEB 4 1969		DATE							
								25b. REGISTRAR'S SIGNATURE [Signature]									

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VR 1-14
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00069

00069

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) CHARLES			First Middle Last FRANKLIN PAINTER			2a. DATE OF DEATH Month 1 Day 6 Year 69			2b. HOUR 10:15 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-7-99			6. AGE (In years (b) birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.				
10. CITY OR TOWN OF DEATH CUMBERLAND,			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) DAVIS MEMORIAL HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) Tire room worker			12b. KIND OF BUSINESS OR INDUSTRY Kelly Tire		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) CUMBERLAND			13b. CITY OR TOWN CUMBERLAND			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 122 POLK ST.		
14. FATHER'S NAME First Middle Last BARNEY PAINTER			15. MOTHER'S MAIDEN NAME First Middle Last JANE A. Longerbean								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-03-7439			17. INFORMANT HOSP. REC. Mrs. Gladys M. Painter, 122 Polk St. Cumb. Md. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 486X IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) pulmonary emphysema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1-4- , 19 69 , to 1-6- , 19 69 , that (I) (we) last saw the deceased alive on 1-6- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Brings				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-8-69					
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS				22e. ADDRESS 57 Greene St. Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1/9/69		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.				
24. FUNERAL DIRECTOR GEORGES H. Wayne George Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR JAN 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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PAINTER

PAINTER

CHARLES

22

2-7-32

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W. VA.

CONFIDENTIAL
HARVARD
ALLEGEDLY
CONFIDENTIAL
X
122 POLK ST.
RETIRED

OFFICE

JANE

PAINTER

BARNEY

220-03-7439 HOSP. REC. CONFIDENTIAL

NO

DR. L. BRINGS

GEORGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 13e Film G 1/29/69 llw Item#13e, Film G409 2									
00070									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
John Frederick Perdue						January 22 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Dec. 9, 1906		62 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		U S A				Allegany		Judy's Market	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Lonaconing		Kyle Nursing Home		Meat Cutter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Allegany		Cumberland		XX		412 Columbia St. 88/Jackson	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John M Perdue			Nellie Cessna						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-05-8586		Ann Perdue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Chronic Pulmonary fibrosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Generalized arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from 1964, to Jan. 23, 1969, that (I) (we) lost the deceased on Jan. 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
L.R. Miles, Jr.		M.D.		X				1-24-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
L.R. MILES, JR., M.D.		LONA CONING MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		1/25/1969		Rosehill Cemetery		Cumberland		Alleg Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Jr., 230 Balto Ave. Cumberland		JAN 27 1969		Charles Judge					

00870

DEPARTMENT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00071		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		00071	
Item 8 Film 409 2/7/69 kk					
1. DECEASED-NAME (Type or print)			First Middle Last		2a. DATE OF DEATH @ 3:10 P.M. Month Day Year
John Gilbert Pfaff					January 25, 1969 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Male	White	7/16/1899		69 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	U. S. A.	Allegany County Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Allegany County Infirmary		Male Pract. Nurse	Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Allegany	Frostburg		200 E. Main Street	
14. FATHER'S NAME	First Middle Last	15. MOTHER'S MAIDEN NAME		First Middle Last	
Gilbert	Pfaff	Sara		Saurbaugh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT		Address	
No	400-12-071641	P.O. Box 599, Allegany County		Cumberland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Pneumonia</u>					7 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic A.S.H.D. & Hypertension</u>					many years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>					many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral thrombosis - Hemiparesis, right & aphasia. 10/66 Coronary occlusion 1/67</u>					<u>Diabetes Mellitus</u>
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8/14/1967, to 1/25/1969, that (I) (we) lost the deceased on 1/25/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED	
John A. Topper				1-28-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
John A. Topper M.D.		Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
BURIAL	JAN. 27, 1969	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.		
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
M. SOWERS	HAFER-SOWERS FUNERAL		FEB 3 1969	Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Bessie				Potts	Jan 28 Day 69 Year		720PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
Female		White		Jan 4, 1893		76 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		America				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland		Cumberland Nursing Center		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Allegany		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		109 Weber Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Price				Shipley	Amanda Jane			Fletcher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name unknown <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		215-34-4856		Rhea Smith		217 Frost Ave		Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Stroke Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-9-56 19, to Jan., 19 69, that (I) (we) lost saw the deceased alive on 1-28-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
G. Overton Himmelwright, M.D.					133 Va. Ave., Cumberland, Md. 21502				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN 31, 1969		FAIRVIEW CHRISTIAN CEMET.		INGLESMTB BEDFORD PENNSYLVANIA			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Silcox Merritt		404 DECATUR ST CUMBERLAND		DATE FEB 3 1969		Charles Judge			

00013

RECORD OF DEATH

00013

112 Front Ave

General Vascular Accident

young

Multiple Sclerosis syndrome

metastatic carcinoma of the breast

bone

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1-1-50

1-1-50

1-1-50

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Overton, J. D. 112 Front Ave., New York, N.Y.

112 Front Ave., New York, N.Y.

112 Front Ave., New York, N.Y.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00073

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00073

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year MATED <input checked="" type="checkbox"/> 1-22-69			2b. HOUR 12:30 p.m.		
Myrtle B. Ringler											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year January 22, 1969			2d. HOUR 12:30 p.m.
F	White	3/24/1896	72 YRS.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Pa.			U.S.A.						Allegany Co. Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Sacred Heart Hospital			Home			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Penna.			Somerset			Rural			Grantsville, R.D. 1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Briskey			Clara Shumaker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			206-40-8395			Mrs Lucille Wisseman, Grantsville			R.D. 1		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK,</u> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5321</u> (b) <u>CHEMICAL PERITONITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PERFORATED DUODENAL ULCER</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>XX 12 Hours</u> <u>12 Hours</u> <u>12 Hours</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> January 22, 1969				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		1/25/1969		Somerset Co. Memorial		Somerset, Somerset, Pa					
24. FUNERAL DIRECTOR <u>Stanley M. Thomas, Salisbury, Pa</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						DATE JAN 24 1969					

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• **RESEARCH**

From January

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200-40-833 Mr. Lucille Kinsman, Grandville

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CHINESE JOURNAL OF CHEMISTRY

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Journal of Interpersonal Violence

2001/05/11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-10
30M REV. 11-68

00074												00074															
1. DECEASED-NAME (Type or print) Helena Sarah Robertson												2a. DATE OF DEATH Jan. 27 1969												2b. HOUR 10A-M			
3. SEX Female				4. RACE White				5. DATE OF BIRTH Dec. 22, 1879				6. AGE (In years last birthday) 89 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.															
10. CITY OR TOWN OF DEATH Barton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Allegany				13c. CITY OR TOWN Barton				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER											
14. FATHER'S NAME First Thomas Middle P Last Lyons				15. MOTHER'S MAIDEN NAME First Sarah Middle Ann Last Morris																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO.				17. INFORMANT Address Althea Lashbaugh-Barton, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolus (coronary or cerebral) 4450 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 yrs.																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Small gangrenous area at right knee.																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from December 3, 1968 , to January 27, 1969 , that (I) (we) last saw the deceased alive on January 22, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE William W. Lesh MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 1-28-69																			
22d. PHYSICIAN'S NAME (Type) William W. Lesh				22e. ADDRESS Westernport, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 1/30/69				23c. NAME OF CEMETERY OR CREMATORY Laurel Hill				23d. LOCATION (City or Town) (County) (State) Moscow Mills Md.															
24. FUNERAL DIRECTOR E. L. Boal				ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR JAN 30 1969 DATE				25b. REGISTRAR'S SIGNATURE Charles Judge															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV.

00075		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00075					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Clara		Middle Ross		Last		2a. DATE OF DEATH Jan. Month 21 Day 1969 Year		2b. HOUR 2 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 11, 1892		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany				Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kinchen Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Barton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME James Norris		First Middle Last		15. MOTHER'S MAIDEN NAME Mary F. Hunucher		First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Charles Ross-Rawlings, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Fibrosis of Esophagus DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 6 min 5 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June 19 1968, to Jan 21 19 69, that (I) (we) last saw the deceased alive on Jan 19 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Clay Durrett		22c. DATE SIGNED 1/22/69		22d. PHYSICIAN'S NAME (Type) Clay Durrett		22e. ADDRESS Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/23/69		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City or Town) (County) (State) Moscow Mills, Md.					
24. FUNERAL DIRECTOR E. L. Boral		24a. ADDRESS Westernport, Md.		25a. PREPARED BY REGISTRAR DATE JAN 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

STATE OF TEXAS

County of _____ State of Texas

Know all men by these presents, that _____ of the County of _____ State of Texas

do hereby certify that _____ of the County of _____ State of Texas

is the owner of the following described land, to-wit:

00076

CERTIFICATE OF DEATH

00076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Walter		First Robert		Middle Ross		Last		2a. DATE OF DEATH Month Jan. Day 14 Year 1969		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 18, 1895		6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Westernport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rural		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Westernport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. 1			
14. FATHER'S NAME First William Middle M Last Ross		15. MOTHER'S MAIDEN NAME First Mary Middle L. Montgomery Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 216-05-5757		17. INFORMANT Address Mary Ross Westernport, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal disease 4121 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 3 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 68 , to Jan , 19 69 , that (I) (we) lost saw the deceased alive on Jan. 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James H. Wolverton, Sr		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-16-69					
22d. PHYSICIAN'S NAME (Type) James H. Wolverton, Sr		22e. ADDRESS Piedmont, W.Va									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/17/69		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport Md.					
24. FUNERAL DIRECTOR Ed Bival		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JAN 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00077

CERTIFICATE OF DEATH

00077

1. DECEASED-NAME (Type or print)		First	Mary	Middle	Margaret	Lost	Rown	2a. DATE OF DEATH		Month	Day	Year	2b. HOUR
		ROWAN		MARY		M.		JANUARY			28	1969	5.00A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		WHITE		10-11-22		46 YRS.		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MARYLAND		USA				ALLEGANY							
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
CUMBERLAND		SACRED HEART HOSPITAL		HOUSE WIFE		OWN HOME							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
MARYLAND		ALLEGANY		CUMBERLAND				603 MARYLAND AVENUE					
14. FATHER'S NAME		First		Middle	Lost	15. MOTHER'S MAIDEN NAME		First		Middle	Lost		
JANNIE		E.		LAMP		(SMITH)		ELIZABETH		LAMP			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address							
NO		218-12-5144		HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1578 Paraplegia due to metastatic disease of spine DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of pancreas (body) 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
7-30-68		Retroperitoneal Mass		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
A. J. MIRKIN, M.D.		1-28-69		A. J. MIRKIN, M.D.		115 S. CENTRE ST., CUMBERLAND, MD. 2150							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		Jan. 31, 1969		Restlawn Memorial Gardens		La Vale, Md. Allegany							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
SCARPELLI FUNERAL HOME		CUMBERLAND, MD.		FEB 4 1969		Charles Judge							

ROWAN MARY I. JANUARY 2, 1909 2.00A
 FEMALE WHITE 10-11-22
 HAYLAND ALLEGANY
 CLARENDON SACRED HEART HOSPITAL HOUSE 17E
 HAYLAND ALLEGANY CUNBERLAND XX 602 HAYLAND AVENUE
 WHITE E. LAM (2112) ELIZABETH LANE
 NO 211-12-21A HOSPITAL RECORD, 600 BETH DRIVE, CORN., NO.

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00078

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> Month	<input type="checkbox"/> Day	<input type="checkbox"/> Year	2b. HOUR
ANNA				RUPP	JAN. 9, 1969					3:15 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
FEMALE	WHITE	DEC. 1, 1890		78 YRS.	MONTHS		DAYS		Month JAN. Day 9 Year 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		2d. HOUR
PENNSYLVANIA		U.S.A.		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		ALLEGANY		3:15 P.M.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND		DOA SACRED HEART		HOUSEWIFE		OWN HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		198 GLENN STREET		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
ISAAC		WILLIAMS		MARY		ANN		JONES		
(Yes, no, or unknown)		(If yes give war or dates of service)		212-54-8086		J. CLANCY RUPP, FROSTBURG, MD. 21532				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										SUDDEN
IMMEDIATE CAUSE (a) CORONARY OCCLUSION										
DUE TO, OR AS A CONSEQUENCE OF										
4109										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										---
(b) CORONARY SCLEROSIS										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1-9-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		CUMBERLAND, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
BURIAL		JAN. 11, 1969		F.B.G. MEMORIAL PARK		FROSTBURG, MD.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD. 21532						JAN 15 1969		[Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last MARTIN W. SCHAEFER			2a. DATE OF DEATH 1 Month 26 Day 69 Year		2b. HOUR 6:40 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8-30-88		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired.) RETIRED MINER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY GARRETT		13c. CITY OR TOWN GRANTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last HENRY SCHAEFER			15. MOTHER'S MAIDEN NAME First Middle Last (LEINSETTER) CHRISTINEA SCHAEFER			Address 900 SETON DRIVE CUMBERLAND, MD.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 215-05-7194		17. INFORMANT HOSPITAL RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary infarct, bilateral 451.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thromboembolism; legs DUE TO, OR AS A CONSEQUENCE OF (c) Prolonged bed rest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Transurethral resection of prostate									
19a. DATE OF OPERATION 1-20-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign Prostate hypertrophy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-9- , 19 69 , to 1-26- , 19 69 , that (I) (we) last saw the deceased alive on 1-26- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE JOSE L. VALDES, M.D.		DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-29-69			
22d. PHYSICIAN'S NAME (Type) JOSE L. VALDES, M.D.		22e. ADDRESS ALGONQUIN HOTEL, CUMB. MD.		22f. ADDRESS 667 E. MAIN ST. PROSBURG, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/28/69		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett Md.			
24. FUNERAL DIRECTOR NEWMAN FUNERAL HOMB, GRANTSVILLE, MD.		ADDRESS		25a. FEB 1969		25b. REGISTRAR'S SIGNATURE			

6:40 6:40 25 1 SCHAEFER W. MARTIN

03 03-20-20 WHITE HALE

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CHURCHLAND HOSPITAL (HART) HOSPITAL

NO. GARRETT GARRETT XX

HENRY SCHAEFER (LEISTER) CHRISTINA

NO 215-02-2104 HOSPITAL RECORDS CHURCHLAND, N.Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00080		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00080							
Items 5&6 Film G408 1/15/69 kk								CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)			First LELA		Middle REBECCA		Last SCHAUB		2a. DATE OF DEATH JANUARY Month 5 Day 1969 Year			2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JAN. 23, 1902 1903			6. AGE (In years last birthday) 66 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) GARRETT		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH FROSTBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MINERS HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1					
14. FATHER'S NAME First OTHA			Middle GARLITZ		15. MOTHER'S MAIDEN NAME First ANNABELIE			Middle DURST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address RT. 1, BOX 572 MISS ANN SCHAUB, FROSTBURG, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic congestive failure DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2 yrs. years			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 1964, to Jan 5, 1969, that (I) (we) last saw the deceased alive on Jan 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE L.R. Miles, Jr. M.D.		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-6-69			
22d. PHYSICIAN'S NAME (Type)		L.R. MILES, JR. M.D.		22e. ADDRESS LONACONING MD, 21537									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE JAN. 8, 1969		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) FROSTBURG, MD.		(County)		(State)			
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR JAN 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00081

CERTIFICATE OF DEATH

00081

1. DECEASED NAME (Type or print) (REV.) ALFRED			First Middle Last JESSE SHAVER			2a. DATE OF DEATH Month 01 Day 05 Year 69			2b. HOUR 12:30 M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 05-01-11			6. AGE (In years last birthday) 57 YRS.		
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) REVEREND			12b. KIND OF BUSINESS OR INDUSTRY CHURCH		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VIRGINIA			13b. CITY OR TOWN MINERAL			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Along River Avenue		
14. FATHER'S NAME First Middle Last SIMON J. SHAVER			15. MOTHER'S MAIDEN NAME First Middle Last (HOTTINGER) MARY C. SHAVER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 236-14-2951		
17. INFORMANT Address MD. 21502			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of stomach</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinomatous</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 2 mos.			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/10, 1968, to 12/31, 1969, that (I) (we) last saw the deceased alive on 1/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J.A. PAGAN, M.D.						DEGREE ATTENDING PHYS.			22c. DATE SIGNED 1/7/69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS 1068 NATIONAL HWY., LA AVLE, MD. 21502					
23a. BURIAL, CREMATION, Removal, or Disposal			23b. DATE 1/7/69			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Franklin, Pendleton, W. Va.		
24. FUNERAL DIRECTOR Wayne George Cumberland, Md. BROWN FUNERAL HOME, FRANKLIN, W. VA.						25a. REC'D BY REGISTRAR JAN 9 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

BRICK FUNERAL HOME, FRANKLIN, N.J.
 100 NATIONAL HWY., LA W/LE, MD. 21502

NO 110
 SACRED HEART HOSPITAL, 300 SECH DE, MD.
 SHAVEN J. (HOTTINGER) MARY C.
 SHAVEN MD. 21502

WEST VIRGINIA MINERAL WILEY FORD
 CUMBERLAND SACRED HEART HOSPITAL LEVEREND
 WEST VIRGINIA U.S.A. X
 11-01-11 27
 CHURCH

(REV.) ALFRED J. SHAVEN
 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. REG. 1-68

00082		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00082			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
CHARLES			E.		SHAW	JAN. 2 1968		2 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
MALE		WHITE		JAN. 26, 1884		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
PENNA.		USA				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		645 BEDFORD STREET		TELLER		BANKING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				645 BEDFORD STREET	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
CHARLES E. SHAW						MARY HEBENER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address
NO			217 14 4126		MRS. NAURENE SHAW				CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-Vase Disease</i> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Heart Disease</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 mo. 1 yr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 15, 1968</i> to <i>Jan. 21, 1969</i> , that (I) (we) last saw the deceased alive on <i>Mar. 31, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Clay E. Durrett</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JAN. 3, 1968		
22d. PHYSICIAN'S NAME (Type) CLAY E. DURRETT, M.D.					22e. ADDRESS 236 VIRGINIA AVE. CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JAN. 5, 1968		HILLCREST BURIAL PARK		CUMBERLAND, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT					25a. REG'D BY REGISTRAR DATE JAN 6 1969		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

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DECLARATION

445 BRIMFORD STREET

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DATE: 1968-11-28

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
00083 CERTIFICATE OF DEATH 00083															
1. DECEASED-NAME (Type or print)			First GEORGE		Middle E.		Last SHOEMAKER		2a. DATE OF DEATH Month 1 Day 3 Year 69		2b. HOUR 10:25 M				
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 7-20-92			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY				Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done regularly for some time) Retired Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Lumber						
13a. USUAL RESIDENCE (Where deceased admitted) MARYLAND			13b. lived, if institution: Residence before 13a. ALLEGANY			13c. CITY OR TOWN OLDTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RT. 1, BOX 72-A					
14. FATHER'S NAME First GEORGE			Middle SHOEMAKER		Last SHOEMAKER		15. MOTHER'S MAIDEN NAME First ANNA			Middle JANE		Last BAER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> unknown			16b. SOCIAL SECURITY NO. 214-05-5611			17. INFORMANT HOSPITAL RECORD, 900 SETON DR., CUMB., MD.				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 2041 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lymphocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1968, to 1/3, 1969, that (I) (we) last saw the deceased alive on 1/3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>[Signature]</u>						M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/3/69							
22d. PHYSICIAN'S NAME (Type) DR. PAGAN						22e. ADDRESS 1068 N.W., HWY. LA VALE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.						25a. REC'D BY REGISTRAR DATE JAN 9 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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GEORGE

NOTE

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CUMMINGS

SACRED HEART HOSPITAL

RETURNED FROM LUNGEY CO.

NAVY

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RT. 1, BOX 72-2

GEORGE

SHOEMAKER

ALMA

JANE

BOB

NO

21-02-211

HOSPITAL RECORD, 900 SECTION OF, CUMMINGS, NO.

RE. PAGE

1000 HAT, H.T. LA VELLE

1000 HAT, H.T. LA VELLE

SCAPPELLI FUNERAL HOME, 108 W. AVE., CUMMINGS, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
Grace Marie Shroyer						1-11-69 19 9 P M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Sept. 27, 1909	59 YRS			January 12, 1969 4:00p M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Pennsylvania		USA				Allegany			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Eellerslie						Dry cleaning			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Allegany	Eellerslie					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward Robb			Emma Corley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No			216-22-6756		Mrs. June Folk, Cumberland, Md. RD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129</u> <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>---</u> (b) <u>---</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			January 12, 1969			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) CUMBERLAND? MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)	(State)
Burial		Jan. 15, 1968	Comps Cemetery			Hyndman, Somerset, Pa.		RD1	
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
Harvey H. Zeigler, Hyndman, Pa.					JAN 17 1969		<u>Charles Judge</u>		

52300

029 T. 1. 1.

1990

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00085 CERTIFICATE OF DEATH 00085									
1. DECEASED-NAME (Type or print)			First MARY Middle ELIZABETH Last SIEFERS			2a. DATE OF DEATH Month Day Year JANUARY 29, 1969		2b. HOUR AM PM 10:20	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 11-20-92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL 900 SETON DRIVE CUMB., MD.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 520 CUMBERLAND STREET	
14. FATHER'S NAME First Middle Last WILLIAM GRABENSTEIN		15. MOTHER'S MAIDEN NAME First Middle Last ANNA GRABENSTEIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-12-8771		17. INFORMANT Address SACRED HEART HOSP -900 SETON DRIVE CUMBERLAND, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1820 Cardiac De compensation 10 days DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Ca of endometrium 1 yr DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerotic Ht. Disease									
19a. DATE OF OPERATION 2 yrs ago.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Vag. Bleeding - Dr.C.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-10, 1969, to 1-29, 1969, that (I) (we) last saw the deceased alive on 1-29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. A. J. Mirking		DEGREE DR. A. J. MIRKING		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-30-69			
22d. PHYSICIAN'S NAME (Type) DR. A. J. MIRKING		22e. ADDRESS 115 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 2/11/69		23c. NAME OF CEMETERY OR CREMATORY SS. Peter + Paul Con.		23d. LOCATION (City or Town) (County) (State) Cumb. Wilkes Co. Md.			
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 3 1969		25b. REGISTRAR'S SIGNATURE John A. Judge			

10082

AM

JANUARY 29, 1960 10:50

CLIFFS

ELIZABETH

MARY

20

11-20-51

WHITE

FEMALE

ALLEGANY

X

USA

MARYLAND

HOUSE/LE

SACRED HEART HOSP

CUMBERLAND

250 CUMBERLAND STREET

ALLEGANY CUMBERLAND X

MARYLAND

ALVIN G. LUTER G. B. HESTER

GRABER HESTER

MILLER

SACRED HEART HOSP - 250 SECON DRIVE

212 12 221

NO

CUMBERLAND, MD.

115 S. CENTRE ST., CUMBERLAND, MD.

DR. A. J. MCKING

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00086

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Harvey William Simons						<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> 1-21-69 198:00p M			<input type="checkbox"/> 1-21-69 198:00p M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	3/11/1887	81 YRS.					January 21, 1969 Year 19 8:30p M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Penna			U.S.A.						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland Rt #3						Retired Employee- P. E. Co					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Allegany			Cumberland					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Webster Simons			Mary Rice								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			214-10-5341			Mrs. Lillian Simons			Rt 3- Bedford Road Cumberland, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										CORONARY OCCLUSION	
IMMEDIATE CAUSE (a)										CORONARY SCLEROSIS	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				BENEDICT SKITARELIC, M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)								JANUARY 21, 1969			
								CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				1/24/69		Hillcrest Burial Park		Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service						Cumberland, Md		JAN 23 1969		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) ALBERT			First C. Middle C. Last STURTZ		2a. DATE OF DEATH Month JAN. Day 17 , Year 1969			2b. HOUR 4:00 A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 07-31-85 1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS 73 DAYS 73 IF UNDER 24 HRS. HOURS 73 MIN 73	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) KELLY TIRE CO.		12b. KIND OF BUSINESS OR INDUSTRY MFG. TIRES			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE PENNA.		13b. CITY OR TOWN WELLERSBURG		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER BOX 3, WELLERSBURG, PENNA. 15564			
14. FATHER'S NAME First JOSEPH Middle STURTZ Last STURTZ			15. MOTHER'S MAIDEN NAME First LILLIE Middle GARY Last GARY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 217-10-6617		17. INFORMANT Address HOSPITAL CHART SACRED HEART HOSPITAL CUMBERLAND, MD. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Heart Disease following bout of flu & pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March , 19 66 , to 1/17 , 19 69 , that (I) (we) last saw the deceased alive on 1/16 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J.A. PAGAN, M.D.		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/18/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1068 NATL HWY LA VALE, CUMB., MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Jan. 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Wellersburg Cemetery Wellersburg, Somerset, Pa.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ZIEGLER FUNERAL HOME		ADDRESS HYNDMAN, PENNA.		25a. REC'D BY REGISTRAR JAN 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

00087

00087

ALBERT	C.	STUTZ	JAN. 17, 1900	1:00
WILE	WHITE	07-3-05	75	
PENNA.	USA	X	ALLEGANY	
CUMBERLAND	SACRED HEART HOSPITAL	KELLY TIRE CO.	HEG, JAMES	
PENNA.	WELLSBURG	X	BOX 3, WELLSBURG, PENNA.	12504
JOSEPH	STUTZ	LILLIE	GRAY	
IN	47-10-047	217-10-0817 HOSPITAL CHART	SACRED HEART HOSPITAL	21502
			CUMBERLAND, N.Y. 21502	



J.A. FAGAN, M.D. 1000 HOTEL HWY E WALE, CUMB., MD. 21502

STICLAR FUNERAL HOME HYNNMAN, PENNA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert the certificate in pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First ROY			Middle T			Last TABLER			2a. DATE OF DEATH Month JANUARY Day 17 Year 1969			2b. HOUR 7:50		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 3-20-92			6. AGE (In years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS 78			IF UNDER 24 HRS HOURS 78 MIN 50		
7a. BIRTHPLACE (State or foreign country) CUMB. MD.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY								
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 622 OLDTOWN ROAD					
14. FATHER'S NAME First AUGUSTA M.			Middle TABLER			Last SAVILLA			15. MOTHER'S MAIDEN NAME First SAVILLA			Middle GLOVER			Last GLOVER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 705-05-8030			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>embolism of pulmonary artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes</u> <u>yes</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19, 1969</u> to <u>January 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>January 19, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Dr. Blane Schindler</u>			22c. DATE SIGNED <u>1/22/69</u>			22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER											
22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.																	
23a. BURIAL, CREMATION, or other disposal Burial			23b. DATE Jan. 20, 1969			23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.								
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE JAN 21 1969			25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>								

00088

00088

ROY

1

TABLER

JANUARY 12 1952 2:20

MALE

WHITE

3-20-92

70

COUB. NO.

USA

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

NO.

ALLEGANY

CUMBERLAND X

622 OLDTOWN ROAD

AUGUSTA M.

TABLER

SAVILLE

GLOVER

105-2-500 MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. BLANE SCHINDLER

43 GREENE ST., CUMBERLAND, MD.

JAN 21 1952

JAN 21 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First BESSIE		Middle E.		Last TAYLOR		2a. DATE OF DEATH JANUARY 23 1969		PM 9:25	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-31-1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN CUMBERLAND		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET AND NUMBER 101 First St					
14. FATHER'S NAME		First GEORGE		Middle E.		Last CLARK		15. MOTHER'S MAIDEN NAME		First ELLEN Middle WILSON Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1/17/69, to 1/23/69, that (we) last saw the deceased alive on 1/23/69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. J. Wms.</u>		22c. DATE SIGNED 1/25/69		22d. PHYSICIAN'S NAME (Type) R. J. WMS.		22e. ADDRESS 122 S. CENTREST., CUMB. MD.					
23a. BURIAL, CREMATION, OR OTHER DISPOSITION Burial		23b. DATE 1/27/69		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) Westernport (County) Md.					
24. FUNERAL DIRECTOR E. S. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR JAN 30 1969		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>					

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00090

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR		
Charles			Thompson			1-8-69 19			3 A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Year			2d. HOUR
Male	White	April 14, 1894	74 YRS.					1-8-69 19			3 A M
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U S A						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Retired Laborer			B & O R R		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Allegany			Cumberland			Route 2, Valley Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Edward Thompson			Mary Eli Thomas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			---			Memorial Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)									CORONARY OCCLUSION CORONARY SCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			January 8, 1969		
						ADDRESS (Street, city, town, or County)			CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Jan. 10, 1969			Allegany County Cemetery Cumberland			Alleg Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John J. Hafer, Jr.			230 Balto Ave. Cumberland, Md.			JAN 10 1969					

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INVESTIGATION OF DEATH

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CORONARY AUTOPSY

REPORT

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Elise Taliaferro Towler						OF ESTI-DEATH MATED <input type="checkbox"/> 1-18-69 17:50a M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	June 22, 1908	60 YRS.					1-18-69	19 7:50a M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Memorial Hospital-DOA			Owner & Operator		Hotel Inn	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland		YES	229 Baltimore Avenue	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Ernest Hunter Taliaferro						Ella Hartley Cave			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No						Lindsay C. Taliaferro, Sr., Pheonix, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) ----- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			January 18, 1969			
			ADDRESS (Street, city, town, or county) Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/21/69		Hillcrest Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR <i>Charles E. Hafer</i>			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.						JAN 21 1969		<i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00092 CERTIFICATE OF DEATH 00092									
1. DECEASED-NAME (Type or print) First Middle Last Hattie Mae Valentine			2a. DATE OF DEATH @ 12:50 P.M. Month Day Year Jan. 8 1969			2b. HOUR 12:50			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3/1/1886		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany		Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Allegany Co. Infirmary		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Unk.	
14. FATHER'S NAME First Middle Last Samuel Hughes			15. MOTHER'S MAIDEN NAME First Middle Last Mary Jane ???						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 220-10-2442		17. INFORMANT Address Mr. Gilbert T. Garlitz, Cumberland, Md. Son				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen. arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased, from <u>Sept 5</u> , 19 <u>68</u> , to <u>Jan 6</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>Jan 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George M. Simons, M.D.</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/7/1969		
22d. PHYSICIAN'S NAME (Type) George M. Simons, M. D.					22e. ADDRESS Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR DATE JAN 10 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 00093
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Grace Middle -- Last Vang			2a. DATE OF DEATH Jan. Month 18 , Day 69 Year		2b. HOUR 8:20 P M
3. SEX Female		4. RACE White	5. DATE OF BIRTH Jan. 31, 1886		6. AGE (In years last birthday) 82 YRS.
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.
10. CITY OR TOWN OF DEATH Cumberland,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumb. Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland,	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 224 Schley St.			
14. FATHER'S NAME First Frank Middle -- Last Spaulding		15. MOTHER'S MAIDEN NAME First Alida Middle -- Last Teeter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-44-3962		17. INFORMANT Address Texas, 78852 Mrs. Durand T. Becker P.O. Box 175 Eagle Pass	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchial pneumonia 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. generalized arteriosclerosis, chronic. (c) Chronic brain syndrome.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years 5 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Latent depressed state.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 7 October , 19 59 , to 18 January , 19 69 , that (I) (we) saw the deceased alive on 17 January , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. A. Van Ormer, M.D.		DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 20 January 1969	
22d. PHYSICIAN'S NAME (Type) W. A. Van Ormer, M. D.		22e. ADDRESS 122 So. Centre St. Cumberland, Md.			
23a. BURIAL, CREMATION, RESURRECTION (Specify)		23b. DATE 1/22/69		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,	
23d. LOCATION (City or Town) Cumberland,		(County) Allegany		(State) Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR JAN 27 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]	

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doi:10.1017/S0022292400002334

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00094											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Mary			Ann	Webel	Jan. Month 7, Day 69 Year			4:50 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		White		Nov. 17, 1891		77 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY			
New York,		U. S. A.				Allegany		Dept. Store			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Cumberland,			Memorial Hosp.			Clerk,					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Allegany		Cumberland,		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		699 Gephart Dr.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Richard			--	Jones	Mary			--	Donovan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No.			111-30-4793			Mrs. Marie Hartnett			132-40 220 St. Gardens, Springfield N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial infarction</u> (c) <u>Myocardial infarction</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1538</u> <u>1538</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1969</u> , to <u>July 7, 1969</u> , that (I) (we) lost the deceased alive on <u>July 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Blane M. Schindler</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED Jan. 8, 1969		
22d. PHYSICIAN'S NAME (Type) Blane M. Schindler, M. D.						22e. ADDRESS 43 Greene St. Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1/11/69			St. John's Cem.			Middle Village Queen's N. Y.		
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.						25a. REC'D BY REGISTRAR JAN 10 1969			25b. REGISTRAR'S SIGNATURE <u>H. Wayne George</u>		

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REMARKS OF CASE

DATE OF DEATH: 1911.11.11

PLACE OF BIRTH: 1911.11.11

PLACE OF DEATH: 1911.11.11

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PLACE OF DEATH: 1911.11.11

PLACE OF BIRTH: 1911.11.11

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00095

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1969

1. DECEASED-NAME (Type or Print) JANNIE			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Jan. 4, 1969			2b. HOUR 6:35 ^a _M		
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH July 21, 1906	6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 0	DAYS 0	IF UNDER 24 HRS HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD January 4, 1969			2d. HOUR 6:35 ^a _M
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital-DOA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE South Carolina			13b. COUNTY Florence		13c. CITY OR TOWN Florence		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 104 Kemp St.		
14. FATHER'S NAME Horace Lane			First Middle Last			15. MOTHER'S MAIDEN NAME Roxanna Kelly			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None Unk.			17. INFORMANT ADDRESS Arie Pickins Florence, South Carolina					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: CORONARY SCLEROSIS (b) ---- DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED January 4, 1969			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City or Town) (County) (State) Florence, Florence, S. Car.			
24. FUNERAL DIRECTOR ADDRESS Philip B. Wendt 121 Memorial Ave. Cumb., Md.						25a. REC'D BY REGISTRAR DATE JAN 8 1969		25b. REGISTRAR'S SIGNATURE W. B. Quidar			

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RESEARCH EXAMINING CENTER OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~please~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
00096					CERTIFICATE OF DEATH					00096						
1. DECEASED-NAME (Type or print) ANNABELLE					First Middle Last (BRODE) WHETSTONE					2a. DATE OF DEATH JANUARY Month 7 , Day 1969 Year					2b. HOUR M	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH OCT. 15, 1899			6. AGE (In years last birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.							
10. CITY OR TOWN OF DEATH FROSTBURG			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 58 LINDEN STREET			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN FROSTBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 58 LINDEN STREET						
14. FATHER'S NAME First Middle Last PHILLIP BRODE					15. MOTHER'S MAIDEN NAME First Middle Last ELIZABETH SLEEMAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 214-07-5362			17. INFORMANT Address PETER G. WHETSTONE, FROSTBURG, MD.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic heart disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 6-15 , 19 65 , to 1-7 , 19 69 , that (I) (we) last saw the deceased alive on 1-4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE H.C. Diehl M.D.			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1-8-69							
22d. PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.			22e. ADDRESS FROSTBURG, MD.													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE JAN. 9, 1969		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK			23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.								
24. FUNERAL DIRECTOR JOSEPH R. DURST, FROSTBURG, MD. 21532			ADDRESS			25a. REC'D BY REGISTRAR JAN 9 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge							

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FINANCIAL STATEMENT

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FINANCIAL STATEMENT

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00097

00097

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rawlings		c. LENGTH OF STAY IN lb 10yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1, Rawlings		d. STREET ADDRESS Route #1, Rawlings	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Wesley Whetzel		4. DATE OF DEATH January 6th, 1969	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4th, 1871	
9. AGE (In years lost birthday) 97 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Petersburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Israel Whetzel		14. MOTHER'S MAIDEN NAME Mary Jane Watts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 236-78-5335	
17. INFORMANT Alma O. Whetzel Address Box 64, Keyser			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED 1/6/1969	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 8, 1969	
23c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		23d. LOCATION (City or Town) (County) (State) Elk Garden, WV	
24. FUNERAL DIRECTOR Allen M. Kotanek, Keyser WV		25a. REC'D BY REGISTRAR 1 JAN 8 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
ISAAC			M		WHISNER	Month 1 Day 23 Year 69			7:15A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
MALE		WHITE		3-1-78		90 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
WEST VIRGINIA		U.S.A.				ALLEGANY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			RETIRED Maintenance-Municipal				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16 POTOMAC ST.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost	
Isaac			Whisner			Julia			?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no					MEMORIAL HOSPITAL CUMBERLAND MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Scrubbing a tub with the head down</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Spontaneous internal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>41/23</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1969</u> to <u>Jan 22, 1969</u> , that (I) (we) last saw the deceased alive on <u>Jan 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Dr. B. Schindler</u>							<u>1/24/69</u>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
DR. B. SCHINDLER					CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Jan. 25, 1969		Sunset Memorial Park		Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.					JAN 27 1969		<u>Charles Judge</u>			

00008

MALE	WHITE	3-1-78	WHICHER	1	23	00 7:15A
WEST VIRGINIA	U.S.A.	X	ALLEGANY			
CUMBERLAND	MEMORIAL HOSPITAL		RETIREMENT			
MARYLAND	ALLEGANY	CUMBERLAND	X	10	POTOMAC ST.	
JAMES	WHICHER					
NO			MEMORIAL HOSPITAL	CUMBERLAND		

DR. F. SCHINDLER CUMBERLAND, MD.

Jan. 27, 1969 Cumber Memorial Hosp. Cumberland, Md.
Cumber Memorial Hosp. Cumberland, Md.

CERTIFICATE OF DEATH

00099

00099

1. DECEASED-NAME (Type or print)		First ROGER	Middle C.	Last WILLISON	2a. DATE OF DEATH Month Day Year JANUARY 2 1969		2b. HOUR 3:30			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-3-12		6. AGE (In years last birthday) 58		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY			Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital name) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. CITY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER YMCA 217 BALTIMORE ST.			14. FATHER'S NAME First Middle Last JOHN WILLISON			15. MOTHER'S MAIDEN NAME First Middle Last ISORA DRENNING				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>yes</i>			16b. SOCIAL SECURITY NO. <i>WW II</i>			17. INFORMANT MEMORIAL HOSP. CUMBERLAND, MD.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>480x</i> <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21</i> , 19 <i>68</i> , to <i>Jan 2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Jan 2</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Blane M. Schindler</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>1/2/69</i>				
22d. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.			22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.							

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>1/5/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hellcrest Burial Pk. Cumberland, Allegany Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany Md.</i>	
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumb. Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JAN 6 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
00100									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
THORNTON			NMI WILSON			1 Month 14 Day 69 Year		6:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		12-14-1909		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life when it retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		RAILROAD machinist		RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				ROUTE 4 -OLDTOWN ROAD	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
SAMUEL THORNTON			ADELINE TWIGG THORNTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (not known)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
NO					900 SETON DRIVE SACRED HEART HOSPITAL CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema bilateral</u> 5320 DUE TO, OR AS A CONSEQUENCE OF + (b) <u>Small bowel Infarction due to venous Thrombosis</u> 12 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Massive Gastrointestinal hemorrhage from duodenal ulcer</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>None</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
1/13/69		Bleeding duodenal ulcer		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/13, 1969, to 1/14, 1969, that (I) (we) last saw the deceased alive on 1/14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Andrew Stasko MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/15/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DR. ANDREW STASKO				401 DECATUR ST -CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, OR OTHER		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 17, 1969		Hillcrest Burial Park		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				JAN 20 1969		[Signature]			

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CUMBERLAND, WYLAND

SACRED HEART HOSPITAL

TO

401 DECATUR ST - CUMBERLAND, MD. 21025

DR. ANDREW STAVKO

General, 17, 1909 Hill Street, Baltimore, Maryland, 21201

General, 17, 1909 Hill Street, Baltimore, Maryland, 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First Sharon			Middle Marelene			Last Wilt			
3. SEX Female			4. RACE White		5. DATE OF BIRTH April 14, 1950		6. AGE (In years birthday) 18		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegany			
10. CITY OR TOWN OF DEATH Rural-Near Westernport			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) not employed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany			13c. CITY OR TOWN Westernport			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME Richard			First Middle Last Wilt			15. MOTHER'S MAIDEN NAME Margaret			First Middle Last Broadwater			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-54-8044			17. INFORMANT Evelyn Weicht			ADDRESS Everett, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 873 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carbon Monoxide Poisoning</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Exhaust of Auto)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 2 Hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Exposure in near freezing temperature</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH About 11:30PM 1-17-69				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1-17-69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) In parked car with engine running				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Road				21f. LOCATION Street or R.F.D. No. City or Town County State Mill run road near Westernport, Allegany, Maryland				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED JANUARY 19, 1969				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Jan. 21, 1968			23c. NAME OF CEMETERY OR CREMATORY Tasker Cemetery			23d. LOCATION (City or Town) (County) (State) Cross Mineral W. Va.			
24. FUNERAL DIRECTOR <u>E. L. Boal</u>						ADDRESS Westernport, Md.			25a. REC'D BY REGISTRAR JAN 22 1969			
									25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MIDIA EXAMINER'S REPORT OF DATA

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FOR STATE

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 100-100-1. Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 5 Film 6098
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
1/17/69 00102 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00102

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Loretta			Windemuth			Month Day Year			8:05M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	White	Jan. 17, 1969	78 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			8:05M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			Md.
Cumberland Md.		U.S.A.		WIDOWED		DIVORCED		Allegany			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland Md.			D.O.A. Memorial Hospital			Housewife.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Allegany		Cumberland.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D. #5 Cumberland Md.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last					
George Windemuth			Elizabeth Anna Mudge.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Mrs. Albert Klavuhn.			R.F.D. #5 Cumb. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY SCLEROSIS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Jan 9, 1969		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal			1/12/69		St. Luke's Cem.		Cumberland Allegany		1969		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Louis Stein Inc.			Cumb. Md.			DATE JAN 13 1969			J. Charles Mudge.		

00103

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES

Division

Office

Report made Jan. 15, 1903

Compared with Jan. 15, 1902

Station No. 1000

Altitude 1000 feet

Locality 1000 feet

Mr. Albert H. H. H. H.

UNIVERSITY OF CALIFORNIA

STATION 1000

X

X

X

Jan. 15, 1903

X

UNITED STATES DEPARTMENT OF AGRICULTURE

00103

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film 408 1/17/69 00103 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										00103		
1. DECEASED-NAME (Type or Print) Rose May Wolford					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Jan. Day 2 Year 1969					2b. HOUR 7 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 5, 1890		6. AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS 78 DAYS 78		IF UNDER 24 HRS. HOURS 78 MIN. 45		
7a. BIRTHPLACE (State or foreign country) West Va.			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Allegheny		2c. DATE PRONOUNCED DEAD Month January Day 2 Year 1969	
10. CITY OR TOWN OF DEATH Cumberland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY House	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Va. COUNTY Hampshire				13b. CITY OR TOWN Augusta		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ---				
14. FATHER'S NAME John W. Hott					15. MOTHER'S MAIDEN NAME Jermina (Hott) Hott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. 214-52-1825		17. INFORMANT Elmer Wolford			ADDRESS Augusta, West Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 5339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) EXANGUINATION DUE TO, OR AS A CONSEQUENCE OF (c) PEPTIC ULCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5400												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED January 2, 1969				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Malick Cemetery				23d. LOCATION (City or Town) (County) (State) Augusta, Hampshire W Va.				
24. FUNERAL DIRECTOR Wade L. McKee				ADDRESS Augusta, W Va				25a. REC'D BY REGISTRAR JAN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

00103

00103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

WOLFORD WAY

People Home, Inc., 1980

WOLFORD WAY

WOLFORD WAY

John H. Wolf

John H. Wolf

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

WOLFORD WAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
MILORED			Martha			WORKMAN			1 Month 28 Day 89 12:35				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE		WHITE		Apr. 24, 1894			74		9 MONTHS 2 DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MARYLAND			U.S.A.						ALLEGANY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL						House Wife		Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
W. VIRGINIA						KEYSER				50 N. MAIN ST.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
FULLER			BARNARD, Sr.			ADA Cannon			ATKINS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No			None			Memorial Hospital			CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Carcinomatosis with Brain metastases</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adeno-carcinoma, hepatic flexure Colon,</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>2 pm</u> , 19 <u>69</u> , to <u>2:45 pm</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>26 Jan.</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>W.A. VanOrmer, M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>1-27-69</u>				
22d. PHYSICIAN'S NAME (Type) <u>W.A. VanOrmer M.D.</u>						22e. ADDRESS <u>CUMBERLAND, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Jan. 29, 69			Queens Point Cem.			Keyser Mineral W.Va.				
24. FUNERAL DIRECTOR <u>Harold W. McKenzie</u>						ADDRESS <u>Keyser, W.Va.</u>			25a. REC'D BY REGISTRAR <u>JAN 31 1969</u>				
									25b. REGISTRAR'S SIGNATURE <u>Johnnie Judge</u>				

00102

STATE OF TEXAS

12:32:32

WORKMAN

MILITARY

73

4-24-92

WHITE

FEMALE

ALLEGANY

U.S.A.

MARYLAND

ONE

Room 12

MEMORIAL HOSPITAL

CUMBERLAND

50 N. MAIN ST.

KEYSER

W. VIRGINIA

ATKINS

ADA Cotton

BARNARD, JR.

EULER

CUMBERLAND, MD.

MEMORIAL HOSPITAL

Room

To

O

1-27-92

CUMBERLAND, MD.

DR. A. J. MICKIN

W. Va.

Keyser

Green Point Dam

Jan 22, 92

1912

JAN 21 1912

Keyser, W. Va.